12-05980 Mary Dunbar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 2222 hrs اعطانها Examiner August 9, 2012 Mary Frances Dunbar 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 06/12/1922 VA 223-22-3863 1 M 2 X F 90 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f shov Calvert St. Leonard permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6569 Marshall Road 20685 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? Never Married 2 Yes 2 X No ᄄ If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 X Widowed White Divorced è 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Secretarial Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Service 2 Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Ellen Large

19b. Mailing Address (Street and Number or Rural Route Number, City or own, State, Zip Code) Thomas Lakey 19a. Informant's Name/Relationship (Type, Print) Ruckersville VA 2296

Date | 20c. Location - City or Town, State Cedar Dr Thomas Dunbar/Son 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mem'l Gdn's 8/16/12 Dunkirk, MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Pervice Licensee Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. edical Death a. Cardiomyopathy complicated by femur fracture Immediate Cause (Final disease miner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical **AMENDED** UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? ıse Pregnant at time of Other (Specify) 1 Yes 2 V No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknowr Atrial fibrillation, pacemaker, dementia Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes Yes 2 V No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 1 V Yes Certification: To 28a. Date of Injury (Month, Day Year) Aug 9, 2012 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject fell 0220 hrs within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural 1 Yes 2 ✔ No 5 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) 13325 Dowell Road , Solomons, MD (Specify) Nursing Home Homicide 29a. Certifier 1 Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif August 10, 2012 O.C.M.E. DRW 10 who completed cause of death (item 23a) 30. Name and address of person Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Mary G. Riggie MD. OCME 32. Registrar's Signature 31. Date filed (M State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27502 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20°1′2 Wallace deWitt, Jr. 4:20 A August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy Kline Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 1 M 2 □ F 217**-**44-0237 10/06/1920 91 PA Usual Residence of Decede or then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Glenwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21738 15474 Roxbury Rd. USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Geologist U.S. Geological Survey Be 17. Father's Name (First, Middle, Last) ige 1 and 2 should be filed int of Health end Mental H Etfitem 27 Is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Wallace deWitt, Sr. Alice Catherine Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Farro/daughter 4293 Molesworth Terrace, Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I Importent: If its eny Injury or of 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 08/10/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, MD 21771 23a. Part 1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) mphama Neeks Medical Due to (or as a consu Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physician and I for use as the burial-transit The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year signed by the el g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? certificate 1 ☐ Yes 2 ☐ No ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Mary Jane DiGenno 11:30 A M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Federalsburg 3471 Houston Branch Road Caroline 8. Date of Birth (Month, Day, Yea June 17, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 222-16-9670 Days Hours **Director** 1 M 2 XF 84 1928 Delaware Usual Residence of Decedent or 28a-f show 10a. State filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Caroline Federalsburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3471 Houston Branch Road 21632 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 【X No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify. Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Jester Mary Ellen Breeding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6975 Reliance Road, Federalsburg, MD 21632 Wayne L. Trice/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Federalsburg, MD 8/18/12 4 Donation 5 Other (Specify) Hill Crest Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 10 disease or condition resulting in death) 409 Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Great in the past 12 months? Day Year been signed by the s should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of ntribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an page 2 autopsy performed? 1 Yes 2 No prior to completion of cause of death? Director: After this certificate 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 2 Acciden
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and Attle of certifier 29d. Date signed (Morith, Day, Year, gus 8 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 100 NAA

DHMH 17 Rev 06-2011

Registrar

Month, Day, Year)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day **FLORA MYRNA EVANS** 2012 1533 PM 08 Medical DA 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 304156414 TONINGULA BEGISNAL NICONICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 214-32-0645 Director 1 M 2 XF 78 06/07/1934 Maryland Usual Residence of Deceder r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset 1 Yes 2X No Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26569 Mariners Road 21817 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give 2 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Operator Verizon å permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othn any Injury or other traumatic event, once. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willard E. Landon Alva Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry W. Evans (Husband) 26569 Mariners Road - Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunnyridge Mem. Park 08/12/2012 Crisfield, MD 21. Signatur of Fun al Savice 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, <u>306 W. Main St.-Crisfield.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metasteria Onset and Death Physician Carcinone disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Lisease or injury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 1 Yes 19 Day Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate hes been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 24 hours after death.

2 Honeral Director: After this certificate heletely filled in by the funeral director, pag. death? 1 🗌 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No Hospital: 1 Yes မြ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Young) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 63199 8112. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 DR SALISBURY, MD 21804 EASTERN SHORE 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:45A M g<sup>Pay</sup> JANE LOUISE ELMER AUGUST 20 ĬŽ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 220-52-4249 Days Hours (Month, Day, Year) 1 □ M 2 1 F 65 **Director** OCT. 21,1946 MARYLAND Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND CECIL RISING SUN 1 Yes 2XXNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1162 EBENEZER CHURCH ROAD UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Specify. Completed 3 🗆 Widowed 4 🗆 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHESTER CRAIG SOPHIE FOREACRE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REV. JAMES MOYERS / MINISTER 377 NOTTINGHAM ROAD, ELKTON, MARYLAND more, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place
NORTH EAST UNITED
METHODIST CEMETERY AUGUST<sub>2</sub>13, 4 Donation 5 Other (Specify) NORTH EAST, MARYLAND 21. Signature of Fundami Service Log 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MULTIPLE SYSTEM ORGAN FAILURE Priysiciani Medical resulting in death) Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner RESPIRATORY FAILURE attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Day Year signed by the af Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ MORBID OBESITY tor: After this certificate has been sig the funeral director, page 2 should t 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death Certificate; 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death To the Funeral Director: A completely filled in by the f Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date s Month, Day, Year) D24034 ne and address of person who completed cause of death (Item 23a) (Type, Print)
TIMOTHY LOW, M.D. 7601 OSLER DRIVE TOWSON, MD 21204

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

**AUG 1** 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Arnold</u> Anne Arundel <u>523 Loughton Lane</u> 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months Min. (Month, Day, Year) Country Director 216-18-1893 1 X M 2 D F Yrs 01/13/1926 86 Maryland Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Arnold MD Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 523 Loughton Lane 21012 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1944-46 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Govmt. N.S.A. Cryptologist & Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Echman <u>John Virgil Greene</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Tacaro Lane, Tracy's Landing, MD 20779 Mary R. Badger, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any Injury o Metropolitan Crematory 8/14/2012 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. MO0715 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examine If any leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at Id be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has autonsy After this certificate 1 Yes 2 No Yes 2 N completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 1 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending Work: 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: Af 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number

dRW10+1

Registrar

DHMH 17 Rev 06-2011

30. Name and address of

31. Date filed (Month, Day,

AUG

empleted cause of death (Item 23a) (Type, Print)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#19a, perINF, G931, 9726/2012, WS State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#19aperFH,8/17/12;BWW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Guillen Andres Aug. 10, 2012 10:00a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death
Montgomery **Examiner** Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Days Hours 1 1930 1927 Nicaragua **Director** 579-11-0341 84 1 🕱 M 2 🗆 F or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20904 USA 11613 Lockwood Drive #T-2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. White 1 Never Married 2 Married 1 🔀 Yes 2 🗆 No Specify Nicaraguan Yes 2x No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates "natural", Specify 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and Mente Important if item 27 is marked any injury or other traumatic angle. ည Juana Guillen Arturo Urbina 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code)
11613 Lockwood Dr. #T-2 Silver Spring
20 19a. Informant's Name/Relationship (Type, Print) Sister Silvia Guillen/Wife Silvia Rosa Guillen- Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Mt.Olivet Cem. Burial 2 Cremation 3 Removal from State 8/13/2012 Frederick, Md 4 ☐ Donation 5 ☐ Other (Specify 21. Signature P部式中 Adrest NALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intercarnial hemorrhage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hypertension, history of stroke 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe 2 🗌 No ☐ Yes 2 🔀 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 은 Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aug.9,2012

State Registrar

DHMH 17 Rev 06-2011

Ousse.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yodit Negusse MD

AUG 13 2012

31. Date filed (Month, Day, Year)

D69288

1500 Forest Glen Rd Silver Spring, Md 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 Month 20 2012 2:45 P Angela Irene Garland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 220-16-2757 86 Director 1 □ M 2 🗓 F 10/22/1925 MD show aţ 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Director MD Carroll Tanevtown Examiner must be notified 28a-f Yes 2 No 10e Street and Number 10f. Zip Code or 10g. Citizen of What Country? items 23a Funeral 316 Clubside Drive 21787 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2X Married 'natural", or þ Yes 2X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the secretary Weller Brothers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Chester Taylor Marybell Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health au :: If item 27 is Claude H. Garland, Sr. 316 Clubside Drive, Taneytown, MD 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Department o Important: If any injury or injury or Carroll Cremation 4 Donation 5 Other (Specify) 08/24/2012 | Hampstead, MD 21. Signature of Funeral Service Pens 22. Name and Address of Proints Funeral Home and Chapel, PA 412 Washington Road, Westminster, MD Part 1. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (o as a consequence of death certificate be executed and -tran Due to (or as a consequence of resulting in death) Last burial Physician/Medical Box 68760 the guip IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Į Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. that the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ è Chixendun V Division of Vital Records, The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforr death? 1 Yes Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Dues low examiner? Hospita Other: 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Thomas funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural Accident 5 Pending s after death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after

To the Funeral Directory

Completely filled in by Medical Certifying Physician: To the best of pa Medical Examiner: On the basis of exa knowledge, dea nination and/or i red at the time, date and place, and due to the cause(s) and manner as stated. on, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner ath occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

28

ause of death (Item 23

Leonard Alden 12-01567 Horsey, In Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2012 27509 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day February 22, 2012 **Medical Examiner** Horsey 1513 hrs eonard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 30931 Park Drive Princess Anne Somerset 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 1 M 2 F 212-21-6171 MD. Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits Mental Hygiene. narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Somerset 1 Yes 2 No Princess Anne must be notified at once, Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at nares. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Somerset 21853 11837 AVE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X No Yes specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ₫. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Environmental College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade Laborer Clean 17. Father's Name (First, Middle, Last) Ja Handy conard 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - wife Cantrelle Somerset Aue, Unit A, Princess Anne, MD21853 Horsey 11877 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Crematory of Delmarva Delmar, DE 4 Donation 5 Other Specify 2. Name and Address of Facility 21. Signat of Funeral Service Licenses Anthony Hampden Ave 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Electrocution and Thermal Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene After this 1 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Subject electrocuted and caught fire FOUND: within 24 hours after death.

To the Funeral Director: 5 Pending 1 Yes 2 ✔ No the Feb 22, 2012 1513 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 30931 Park Drive, Princess Anne, MD (Specify) Outside of factory Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 23, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) Registra AUG 0 9 20

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death 08 08	3 Day 2012	3. Time of Death
إياسهر	Medic	al	Richard Harding, Jr.  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Lacation of Dooth			7:52 A <sup>M</sup>
-	Examin	er	Civista Medical Center		La Plat			4c. County of Death Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
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	or 28 or 28 e noti	قَ	10e. Street and Number	waldoll	10f. Zip Code		10	g. Citizen of What Cou	
	with with s 23a ust b	Funeral	4791 Kittiwake Court		20603			United Sta	tes
	items ler m	Fun	11. Marital Status 12. Was Decedent Ever	r în U.S. 13. V	Vas Decedent of His FYes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	can Indian,
36	after I", or xamit	d by	1 Never Married 2 Married 1 Yes 2 No		☐ Yes 2 <b>X</b> No			Black, White,	
21215-0036	atura cal E	Completed	3 Uvidowed 4 Divorced Year or Dates.	16a Deced	lent's Usual Occupa	tion	1	6b. Kind of Business/In	
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p	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural" or items 20a or 28a-f show maric event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	
<u>₹</u>	should be file n and Mental I ris marked o raumatic eve	1	Richard Harding, Sr.			Betty L	. Harriso	on	
Baltimore, Maryland	1 and 2 should be of Health and Menta fitem 27 is marked other traumatic et other traumatic	(9	19a. Informant's Name/Relationship (Type, Print)	11	_			ity or Town, State, Zip	· ·
Ġ,	and Heali tem 2		Richard Harding, III/Son  20a. Method of Disposition	20b. Place of Dispo		court w		Maryland 20 Oc. Location - City or To	
<u>o</u> r	Page 1 ment of ant: If it		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cren	natory or other place 1d-Echols			Charlotte H	
闄	permit. Page 1 Department of Important: If it any injury or o	Ţ.	21. Signature of Funeral Service Licensee						Home, P.A.
m	any per	(1)	MO14					ta, Marylan	
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
~1	h sician/	g ()	Immediate Cause (Final disease or condition Care	cinoma La	rvnx				Onset and Death
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Š ×	requires that the death certific been signed by the attending should be detached for use as	ian/	23b. Was decedent pregnant 23c. If yes, outcome of print the past 12 months? 1 Live Birth 2	☐ Fetal death 3 ☐		/		23d. Date of deliv	
Box	e death the atter	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tin 9 ☐ Unknown 9 ☐ Unknown	ne of death 5 ∟	Other (specify)			Month	Day Year
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ě	The law ate has page 2 s	oml					autopsy	ed? death?	mpletion of cause of
<u>a</u>	ling Physician: The law in the law in the law in this certificate has be funeral director, page 2 s	Be C	25. Was case referred to medical examiner?		26. Pla	ce of Death (Chec	1 Yes 2 k only one)	NIO 1 les	2 🗆 110
VITal	hysic his ce al dire	To	1 ☐ Yes 2 🔀 No Hospital:	2x ER/Outpatien	t 3 DOA Other	4 Nursing Ho	ome 5 Residence	ce 6 Other (Specify	)
jo	ing P	ate:	27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation	ear) 28b. Time of injury	28c. Injury work?		28d. Describe how	injury occurred	
30	ttend death stor: / y the	Certificate:	3 Suicide 6 Could not be	At home form stre		/es 2 □ No	00f 1ti (Ot	and the second second	Don't Market
Division of	I or A after Direct		4 Homicide determined building, etc. (S		et, lactory, office		City or Town, S	et and Number or Rural State)	Houte Nurriber,
_	ospita hours uneral	Medical	29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death o	ccurred at the time,	date and place, a	nd due to the cause	e(s) and manner as state	ed.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Me	(Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practitioner: To the	imation and/or invest est of my knowledge,	death occurred at the	e time, date and pla	t the time, date and pace, and due to the c	place, and due to the cal cause(s) and manner as	use(s) and manner stated.
	With Cor		29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Month, I	Day, Year)
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	Box		30. Name and address of person who completed cause of death	n (Item 23a) (Type, P ◆	50 POS	st Oth	i'ce R	d #30	y worldon't
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State

31. Date filed (Month, Day, Year) AUG 1 3 2012 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death August 7, <sup>D</sup>**2**012 1:15a Dorothy Harris 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homecrest Assisted Living Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 13, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🏅 F Days Hours Maryland 579-44-0361 86 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 ☐ X/es 2 ☐ No Washington DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1837 Kilbourne Place, 20010 **United States** N.W. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Force 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates Specify: African 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Private Homes Domestic Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Wayne Mary Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Harris/Son 10727 Casper Street, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/14/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln **Memorial** 21. Signature of Funeral Service Li 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Be မ Certificate:

(Check

only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Trany, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown		23d. Date of delivery Month Day Year							
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in P	Zoc. Did tope	acco use contribute to the cause of death?							
		24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of ed? death?							
25. Was case referred to medical examiner?		Death (Check only one)								
1 ☐ Yes 2 🗶 No	Hospital: 1 $\square$ Inpatient 2 $\square$ ER/Outpatient 3 $\square$ DOA Other: 4 $\square$	Nursing Home 5 - Residen	Assisted Living compared to the Assisted Living Facility							
27. Manner of Death  1 XNatural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury injury  28c. Injury at work?  1 □ Yes 2	28d. Describe how								
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)							
202 Certifier 1 A Cortifying Phys	inian: To the best of my knowledge, death ecoured at the time, date of	ad place and due to the server	/s/							

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D37142

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 08/07/2012

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending p within 24 hours after death.

To the Funeral Director: After this certific sempleted filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

State Registrar G. Coleman, M.D. 1355 Piccard Drive, Rockville, MD 20850

2. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	Sta	te of Ma	aryland	d / Dep <i>Ce</i>	artment c e <i>rtificate c</i>	f Healt <i>f Deat</i>	th and M Th	lental Hy	giene. Reg. No.	201	2	27512	
ĺ	Physicia	n/	1. Decedent's Name (First, Midd	n Lori	raine	Haq	ins				2. Date of De Month	ath Day	Yea	ar	3. Time of Death 7:05 P <sup>M</sup>	
The same	Medic Examin		4a. Facility Name (if not institution Frederick	n, give street an	d number)			4b. City, Tow	n, or Locat	on of Death erick	Augu	4c.	st 8 2012   7:05 P <sup>M</sup> 4c. County of Death Frederick			
and d	Funeral		5. Social Security Number 229–68–6224	6. Sex	7. Age	e (In yrs. las		If Under 1 Y		nder 24 Hrs.	8. Date of Bir (Month, Da	th	9.		ace (State or Foreign	
4	Director		Usual Residence of Decedent	1 □ M 2	KDE	64	Yrs.				April			/ire	ginia	
	faryland 3a-f sho tified at	ector	10a. State 10b. Count 10c Fred	erick			Town or l							10	od. Inside City Limits 1 ☐ Yes 2🌠 No	
	with the N 23a or 24 ust be not	Funeral Director	10e. Street and Number 5701 Lavender	Plaza				10f. Zip Co 2170				10g. Citiz	zen of What	Count	ry?	
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the fleet at 18 a series 28a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 🔀 Ma 3 Widowed 4 Divorce	Arm arried 1 [	s Decedent Ened Forces? Yes 243 es, Give r or Dates.	Ever in U.S. No	. 13	Was Decedent If Yes, specify (	Suban, Mex	kican, Puerto I	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:		tc.	
Maryland 21215-0036		Completed	15. Deced (Specify only high Elementary/Secondary (0-12)		oleted) ege (1-4 or 5	5+)	(Giv	edent's Usual Oc e kind of work do DO NOT use reti	ne during i	most of workii	ng		nd of Busine			
d 21	ed withi Hygiene other th ent, the	Be Cc	10 17. Father's Name (First, Middle,		-9-(		Sec	retary	18. M	Nother's Name	e (First, Middle,		Govern	men	it	
ylan	ild be fill Mental narked o	2	Unknown						A	Addie W	lade					
Mar	d 2 shou alth and 27 is rr ir traum		19a. Informant's Name/Relation Sheila Johnson	ship (Type, Print n Manio	daug_daug	hter	1	ling Address (Sta l Lavenc							21703	
Baltımore,	Page 1 and 3 ment of Heall ant: If item 2 ury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☒ Other	n 3 🗆 Remova (Specif <b>5 n t o</b>	al from State mbment	ce	ace of Dis metery, cr	oosition (Name of ematory or other	place)	С	Date	20c. Lo	cation - City	or Tov		
Baltı	permit. Page Department of Important: If any injury or once.		21. Signate of Funeral Service		1180	6.1	//	22. Name and A		0	auffer ke, Fr	Fune ederi	eral H Lck, M	ome ary	land 21702	
É		. /	23a. Part 1. Enter the disease, on shock, or heart failure. List Immediate Cause (Final	or complications only one cause	that caused on each line	the death	. Do not e	nter the mode of	dying, such	h as cardiac o	r respiratory ar	rrest,			Approximate Interval Between Onset and Death	
1	Medical Examiner		disease or condition resulting in death)	a. 7	ue to (or as	a conseque	ence of):	enal	Cell	Can	Cinon	19		+	<u> </u>	
J.		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	ue to (or as	a conseque	ence of):							+		
	sate be executed physician and the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as	a conseque	onsequence of):									
09/	cate be physici s the bu	edical		d				_						$\perp$		
Box 68	law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-trans.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ To 9 ☐ Unknown	1 4	es, outcome Live Birth Pregnant a Unknown	2 🗌 Fetal	death 3	Ectopic preg				2	23d. Date of Month		ry Day Year	
s, P.O.	ures that tr signed by lld be detad	by	Part II. Other significant condit	1	ng to death b	out not resu	ulting in the	underlying caus	e given in I	Part I.	1				e cause of death?	
Vital Records,	The law requate last been page 2 shot	Completed									24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy ormed?	prior deat	to con h?	sy findings available npletion of cause of	
Vita	/sician: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	l Hospital	1\ Inpati	ent 2 🗆 i	ER/Outpat	ent 3 🗆 DOA	Other:	Death (Check	<i>conly one)</i> me 5 ☐ Resi	idence 6	Other (S	necify)		
to L	fing Phy T. After this funeral		27. Manner of Death  1 Natural 5 Pend	ling	. Date of inju (Month, Day	iry	28b. Time injury	of 28c.	njury at work? 1 □ Yes		28d. Describe			pooniyy		
Division of	To the Pospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Certificate:	3 🗌 Suicide 6 🗌 Coul	tigation d not be mined	Place of Injubuilding, etc			treet, factory, of			28f. Location ( City or To			Rural i	Route Number,	
<b>□</b>	e Hospita 124 hours e Funeral	Medical	(Check 2 Medical	Examiner: On t	the basis of e	xamination	and/or inv	n occurred at the estigation, in my o ge, death occurre	pinion, dea	th occurred at	the time, date	and place,	and due to t	he cau	se(s) and manner stated.	
	Nithir To th COMP	_	29b. Signature and title of certific					29c. Lid	ense numb	oer _		29d. Date	e signed (Me	onth, D	Pay, Year)	
	6		30. Name and address of person			leath (Item		, Print)	602				9-2			
	Sta	۵.	Hemen Shell 31. Date filed (Month, Day, Year)		32. Registra	La w ar's Signati	ure.	Johns	en	Dr,	Frede	VIEL	MD	217	702	
	Registra			3 2012	Dener	en	D. 7	parkel								

12-06112 Lee Brian Holland

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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						-	-	-	-

		1- For State Registrar		ertificate o	f Death		F	teg. No.	
Phys Medical Exa	sician		,				2. Date of Dea Month		3. Time of Death 2304 hrs
	anning	Lee Brian H  4a. Facility Name (if not institution	olland n, give street and number)		4b. City, Town,	or Location of De	Month August 14	4, 2012 4c. County of	
,		13091 Kibler Road			Greensbo			Caroline	
Fune		5. Social Security Number	6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Y				Birthplace (State or oreign
Direct	.Or	221-38-0011	1X M 2 F 67	Yrs		ays Hours	Jan 8	1945	Country)Illinois
All		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Local	tion				10d. Inside City Limits
<u>*</u>		Maryland Caro		 reensboi					1 Yes 2 No
Maryland	Director	10e. Street and Number		100115501	10f. Zip Code	e	1	0g. Citizen of What	
the N			Road		216	39		USA	
th with	ust be no	11. Marital Status 1 Never Married 2 X Ma	12. Was Decedent Ever in Armed Forces?			Hispanic Origin? oan, Mexican, Pue	(Specify Yes or No	14. Race - / White, e	American Indian, Black,
ter dea	E 0	3 Widowed 4 Dive	1 Yes 2 No	1	×	No specify:	, ,	Specify:	White
ours af	or Dates:								
<b>6</b> 172 hc	the Medical Exam	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working I	ife. DO NOT use	retired)		
5-003 iled withir Hygiene.		12 17. Father's Name (First, Middle, I	4	Vice I	Presider	nt of Ma		Pipelin	e Company
e filed	event, the M		·			1	ame (First, Middle, ret Kane	Maiden Surname)	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene.	tic eve			19b. Mailin	g Address (Str			nber, City or Town,	State, Zip Code)
MD and 2 sho lith and m 27 is	8	Dianna L. Lawr		13091	Kibler	Road; G	reensbor	o, Maryla	
ore, M es 1 and 2 of Health If item 2	her tr	20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from State	Place of Dispos crematory or ot	sition (Name of o her place)	cemetery,	Date	20c. Location - Ci	ity or Town, State
Baltimore, permit. Pages 1 an Department of Hee Important: If ite	7 or of	4 Donation 5 Other Spe	ecify: C1	nesapeak	ce Crema	tion Au	g. 16 201	2 Stevens	sville, MD
Baltimo permit. Page Department o Important:	iji.	21. Signature of Funeral Service L	licensee	22. N	Name and Addre	ess of Facility Po	O Box 160	; Greensl	poro, MD ne, PA; 21639
Physicia		23a. Part I. Enter the disease, or o	complications that caused the deat						
/Medic		failure. List only one cause of Immediate Cause (Final disease	on each line. a. Hypertensive Cardiova	scular Disea	ase				Between Onset and Death
LAGITIM	GI	or condition resulting in death)	Due to (or as a consequence						
	ē	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a consequence	of):		-			
	nsit Examiner	cause Fixer Underlying Cause (Disease or injury that initiated	C.						
uted	Exa	events resulting in death) Last	Due to (or as a consequence d.	or):					
760, ficate be executed 3 physician and	he burial - tra	UNPENDED	AMENDED						
760, icate be s physic	the bu	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre				_	23d. Date of del	livery
Box 68's death certiff	use as	past 12 months?	1 Live birth Pregnant at time of d	eath -	tal death 3 her (Specify)	BEctopic preg	gnancy	Month	Day Year
Box 687 re death certifi	ched for use as Physician	1 Yes 2 No 9 Unkn	_ I 9 _ Unknown						
that th	형   匝	Part II. Other significant condition	ons contributing to death but not	resulting in the u	inderlying cause	given in Part I.			te to the cause of death?
rds, P.C requires that been signed	ted be				<u> </u>				Probably 4  Unknown
COFC law re	; page 2 should be Completed						24a. Was a autop	sy prior	e autopsy findings available r to completion of cause of
tal Rec cian: The certificate	S Page						perfor 1 <b>✓</b> Yes		Yes 2 No
ic certi	director,	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Other Nur		Residence 6 🗸	24 - 2
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by	린 🗀	1 ✓ Yes 2 No 27. Manner of Death	28a, Date of Injury	28b. Time of Ir		jury at Work?		ow injury occurred	Jiner: Scene
ion tendin eath.	ë   ₽	1 Natural 5 Rendin	(Month, Day, Year)		1	Yes 2 No			
Division tal or Attendir safter death.	<b>≐!</b> ≒	_ J_ Feliali							
Pital Ours	tificat	2 Accident Investi 3 Suicide 6 Could	gation not be 28e. Place of Injury - At h	ome, farm, stree	t, factory, office	building, etc.			r Rural Route Number, City
8 4 9	Certifi	2 Accident Investi 3 Suicide 6 Could 4 Homicide	gation not be 28e. Place of Injury - At h	ome, farm, stree	t, factory, office	building, etc.	28f. Location (S or Town, S		r Rural Route Number, City
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certiff hin 24 hours after death.  the Funcral Director: After this certificate has been signed by the attending		2 Accident Investi 3 Suicide 6 Could 4 Homicide 29a. Certifier 1 Certifying Phy	gation not be inined 28e. Place of Injury - At hind (Specify)  sician: To the best of my knowled Iner: On the basis of examination a	ge, death occurr	red at the time,	date and place, a	or Town, S	e(s) and manner as	stated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical Certificat	2 Accident Investi 3 Suicide 6 Could 4 Homicide 29a. Certifier 1 Certifying Phy	gation not be nined (Specify)	ge, death occurr	red at the time, ion, in my opinic	date and place, a	or Town, S	e(s) and manner as	stated. to the cause(s)
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To the Hos within 24 h To the Fun		2 Accident Investi 3 Suicide 6 Could 4 Homicide 29a. Certiffer 1 Certifying Phyone) 2 Medical Exam  29b. Signature and title of certifier  30. Name and address of person w	28e. Place of Injury - At Initiation (Specify)  sician: To the best of my knowled and manner stated.	lge, death occurr and/or investigati n 23a)	red at the time, ion, in my opinic 29c. Licer	date and place, a on, death occurred use number	or Town, S and due to the caused at the time, date a	e(s) and manner as and place, and due t 29d. Date signed	stated. to the cause(s) (Month, Day, Year)
T. vivit	completely	2 Accident Investi 3 Suicide 6 Could 4 Homicide 29a. Certiffer 1 Certifying Phyone) 2 Medical Exam  29b. Signature and title of certifier  30. Name and address of person w	28e. Place of Injury - At half (Specify)  sician: To the best of my knowled and manner stated.	lge, death occurr and/or investigati n 23a) 900 W. Ba	red at the time, ion, in my opinic 29c. Licer	date and place, a on, death occurred use number	or Town, S and due to the caused at the time, date a	e(s) and manner as and place, and due t 29d. Date signed	stated. to the cause(s) (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Doris Theresa Jones 22:14 P M Medical 201 Aug 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 578 78 4119 1 □ M 2 🗶 F 56 Aug 9, 1955 Washington DC ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he motified. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? Funeral 4006 28th Ave Apt 204 20748 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2XX Married 1 Yes : Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 ▼ No Specify: 3 Divorced Specify: **Black** Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Proctor Mable Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Jones (Husband) 4006 28th Ave Apt 204, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Aug 15, 2012 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Lee Fineral Home Crematory 21. Signature of Funeral Service Licensee MO1555 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Day to for any generouse attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year g Unknown Linknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARCINOMA 1 Yes 2 No 3 Probably 4 Wunknown the funeral director, page 2 should ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No 1 Yes ပ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Gartifying Nurse Prectitioner. To the best along knowledge death secured at the time, date and place 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AUGUST JULY, 04, 2012 04,2012 30. Name and address of person who completed cause of death (Item 23a) (Typę, Print)

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH C931 9/28/2012 Than of Health and Mental Hydiana

			For State	State of Marylan	na / Departme <i>Certifica</i>						
			Registrar  1. Decedent's Name (First, Middle, La	ist)	Cerunica	le UI L	<i>Peau i</i>	2. Date of Dea	Reg. No ath	2012	32moor Seath 5
	Physicia Medi		CHAPM	IAN JONE	ES			Month AUG	Da O (		0755 AM
	Examir		4a. Facility Name (if not institution, giv	e street and number)	4b. City		Location of Death	197	4c.	. County of Deat	h
	ž.		HOWARD COUL				LUMBIA  If Under 24 Hrs.				RD COUNTY
	Funeral Director		Land and JUANA	Sex 7. Age ( <i>în yrs. l</i> a 1 1 M 2 □ F 92	Months Yrs.	er 1 Year Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)	Co	thplace (State or Foreign untry)
			Usual Residence of Decedent					Jan. 1.	5, 1	920 Vir	ginia
	yłand -f sho ed at	cto	10a. State 10b. County DC		y, Town or Location  lashington						10d. Inside City Limits
	r 28a	Dire	10e. Street and Number			ip Code			10. 0	tizen of What Co	1X Yes 2 □ No
	e 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	114 Longfellow ST	c., N.W.		0011		ŀ	-	ted Sta	
	death item	E	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		edent of His	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Ame	
336	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 Married Divorced	1 ☐ Yes 2基 No If Yes, Give Year or Dates.	1 ⊡ Yes			,		Black, White Specify: B.	lack
2-0	hours natur dical I	olete	15. Decedent's	Education	16a. Decedent's Us	ual Occupa	ation		16b. K	and of Business/	Industry
21	hin 72 ne. than " e Me	1   Never Married 2   Married   1   Yes 2   No   1   Yes 2   No   Specify:   Specify   Specify									totion
d 2	Hygier Hygier Sther snt, th	Bec	17. Father's Name (First, Middle, Last)		Professi	onai	18. Mother's Nam	- Circle & Sidelle		ranspor	Lation
Maryland 21215-0036	uld be filed within 7 1 Mental Hygiene. narked other than natic event, <u>the M</u>	<u>-</u>	Henry Jones					Broggin		Sumame)	
lary	should and N is ma auma		19a. Informant's Name/Relationship ( Barbara J. Phophe		19b. Mailing Addres	s (Street a	nd Number or Run	al Route Number	r, City or	Town, State, Zir	Code)
	and 2 Health em 27 ther tr		20a. Method of Disposition		5806 Wynd						
Baltimore,	Page 1 nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State Mar	griendie Nact in	one Pace	9) :	Date /2012		re1, MD	Town, State
altir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	See / Mer	morial Par	nd Addres	8/14, s of Facility Mc(		nera	al Servi	ce. Inc.
<u>m</u>	28 E E S		Typice Ih	ugnese						ngton, I	o.c. 20012
			23a. Part 1/Enter the disease, or com shock, or heart failure. List only of		Approximate Interval Between						
	Medical		Immediate Cause (Final disease or condition resulting in death)	a. CONGESTI  Due to (or as a consequ	PAILURI				Onset and Death		
7	Examiner		Constant all that are different	Due to (or as a consequ	derice or).						
-	ed viit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):						
	and and	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):						
0	ficate be executed g physician and as the burial-transit	edical		d							
	tificate ng phy		IF FEMALE:						_		
0 X	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal	al death 3 🔲 Ectopic		/			23d. Date of del	The second secon
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certif this certificate has been signed by the attending ral director. page 2 should be detached for use a	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	death 5 ∐ Other (s	pecify)				Month	Day Year
P.0	that the ned by e deta		Part II. Other significant conditions		ulting in the underlying	cause give	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
ds,	quires en sig ould b	ted k	DEMENTIA	3				1 🗆 ነ	Yes 2	□ No 3 □ Pr	robably 4 Unknown
CO	faw re has be ge 2 sh	Completed by						24a. Was a autop	sy	prior to c	copsy findings available completion of cause of
<u> </u>	sician: The la certificate ha rector, page		25. Was case referred to medical					1 🗆 Yes	rmed? 2 DNo	death?	2 🗆 No
/ita	/sicial	To Be	examiner?  1  Yes 2 No	Hospital:	ER/Outpatient 3 🗆 🗈		ce of Death (Checi			Пан. п	
of	ng Phy ter this		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)		28c. Injury work?		ome 5 ∟ Resid 28d. Describe h			<i>Ty)</i>
ion	tendii death. tor: Af the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not to	on	М	1 🗆 1	∕es 2□No				
ivis	I or Al after Direc d in by		4 ☐ Homicide determined			y, office		28f. Location (S City or Town			al Route Number,
Ц	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phy	vsician: To the best of my knowle	ledge, death occurred	at the time,	date and place, a	nd due to the ca	use(s) ar	nd manner as sta	ated.
	the H thin 24 the F mplete	ğ	only one) 3 ☐ Certifying Nur	niner: On the basis of examination se Practitioner: To the best of m	ny knowledge, death oc	curred at th	e time, date and pla	ace, and due to the	ne cause	(s) and manner as	s stated.
	89₹9		29b. Signature and title of certifier  Myuti'		MD 29	c. License	06476			e signed (Month	, Day, Year) 6, 2012
	7		0	completed cause of death (Item	23a) (Type, Print)						
			MYTHILY VA	NCHA, MD, II	085 Lit	de	Patuxe	ut PKI	uy ,	Suite L	MD' 2104 4
	Stat Registra		31. Date filed (Month, Day, Year) <b>AUG 13</b> 20	og negistrar s olgitati	falls						•

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10   20   20   20   20   20   20   20				State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  State Registrar  Certificate of Death
Scharler of Section (Control definition, operand and number)  Section (Control definition)  Sect	I			
Displayed Body Control of the Country Control				4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  CCC  CCC  4c. County of Death  CCC  CCC  4c. County of Death
Total Designation   Tota		Director		AAA - Ale - Lalle 7 1 M 2 DF Months Days Hours Min. (Month, Day, Year)
Privician  Medical Examiner  Provided to the property of the provided program of the property of the provided program of the provided program of the property of the provided program of the provided program of the property of the provided program of the property of the p		laryland 3a-f show ified at	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
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Privision Modical Examiner  Provision  Provi		filed within all Hygiene.		Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired)  Hairdresser Hair Salon
Privician  Medical Examiner  Provided to the property of the provided program of the property of the provided program of the provided program of the property of the provided program of the provided program of the property of the provided program of the property of the p	ryland	uld be file d Mental H marked o natic eve		Ernest Roberts Huriel N. Johnson
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Physician/ Medical Examiner  Physician Ph	Itimor	Page ment c ant: If ury or		1 Donation 5 Other (Specify)
Physician/ Medical Examiner  Medical Examiner  Physician/ Medical Examiner  Immediate Cause (from a cause of cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause of cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause of cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause of cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequentially list conditions, lary, leading to immediate Cause (from a cause)  Sequen	Ba	perm Depa Impo any i	Į.	Meris D COVGE POBOX 2593 WilHington DE 19805
Due to (or as a consequence of):    Part   Content   Con				shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death  Onset and Death
O C C C C C C C C C C C C C C C C C C C			Je	Due to (or as a consequence ot):  Sequentially list conditions,  b.
O C C C C C C C C C C C C C C C C C C C	D	ecuted and I-transit	xamin	cause. Enter Underlying Cause (Disease or injury that initiated events c.
The state of the s	<u>~</u>	cate be ex physician s the buria	lical	d
The state of the s		the death certificity the attending ached for use as	hysician/M	23c. If yes, outcome of pregnancy in the past 12 months? 1
25. Was case referred to medical examiner?    The property of	ls, P.C	uires that 1 n signed b uld be det	þ	200 See total of the second of
25. Was case referred to medical examiner?    The property of	ecorc	ne law requ e has beer age 2 shou	omplet	autopsy prior to completion of cause of performed?
29a. Certifier (Check only one 2) Certifier (	/ital R	rsician: The secutificat director, pa	Be	25. Was case referred to medical examiner?  Hospital:  26. Place of Death (Check only one)
29a. Certifier (Check only one 2 Certifier Verse Prantitioners: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Substitution of the cause o	on of	nding Phy ath. r. After this ie funeral		7. Manner of Death atural 5 Pending   28a. Date of injury (Month, Day, Year)   28b. Time of injury at work?   28d. Describe how injury occurred work?
29a. Certifier (Check only one 2 Certifier Verse Prantitioners: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Substitution of the cause o	Division	al or Atters after de al Directo		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
* Milleardy, MD 556979 8/8/10		he Hospit in 24 hour he Funera ppletely fill	Medica	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the equipe(s) and manner stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print).		Vith Vor		29c. License number 29d. Date signed (Month, Day, Year)
14. Chardon 253 lewistu, Have da Gaer 21078		6		Name and address of person who completed cause of death (Item 23a) (Type, Print), Havk da Gace, 21078
State Registrar  31. Date filed (Month, Day Year)  AUG 15 2012  DHMH 17 Rev 06-2011		Registra	ar	AUG 15 2012 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-05906 2012 27517 State of Maryland / Department of Health and Mental Hygiene John Alfred Jones, Jr. Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1045 hrs **Medical Examiner** August 7, 2012 JOHN ALFRED JONES, JR 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's Chester 1903 Harbor Drive If Under 1 Year | If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign MARYLAND Months Days Hours Director 07/22/1966 Country) 214-94-2727 46 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No or 28a-f show CHESTER OUEEN ANNE'S MD or items 23a or 28a-f shomust be notified at once. e, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. irector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES ö 1903 HARBOR DRIVE 21619 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No WHITE 1 Yes 2 X No specify: Specify: 4 X Divorced If Yes, Give Year nt of Health and Mental Hygiene.

11: If item 27 is marked other than "oatural", of other traumatic eveot, the Medical Examiner. 3 Widowed ≥ or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) CONSTRUCTION CARPENTER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VERONICA GOTTLEIB Be JOHN A. JONES, SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1904 HARBOR DRIVE, CHESTER, MD 21619 REED JONES / BROTHER 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Itimore, CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State Pages 1 Important or injury or 08/10/2012 STEVENSVILLE, MD 4 Donation 5 Other Specify nature of Funeral Service Licenses 22 Name and Address of Facility FELLOWS, HELFENBEIN 106 SHAMROCK ROAD, & NEWNAM CHESTER. HOME, P.A. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** en Onset and failure. List only one cause on each line. (Medical Death a. Contact Shotgun Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause: Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P. 0. ρ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 ✔ No death? 1 Yes 2 No page certificate 26.Place of Death (Check only one) To the Hospital or Atteodiog Physician; 25. Was case referred to medica of Vital Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Subject shot self Certification: Aug 7, 2012 Natural 1030 hrs 1 Yes 2 ✓ No Division Director: Pending hours after death. Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1903 Harbor drive, Chester, MD within 24 hours a. To the Fuoeral L determined pecify) At home Homicide 29a. Certifier 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physic Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Medical Exami 2 🗸 and manner stated 29b. Signature applittle of certife 29d. Date signed (Month, Day, Year) 29c. License number tw O.C.M.E. August 8, 2012 Slalia

OCIVIE Registrar 30. Name and add

Ripole MD

9

900 W. Baltimore Street, Baltimore, MD 21223

of persor who impleted cause death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 1<sup>Day</sup> Physician/ 20**°1**°2 3:00 AM William Charles Knox Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Caroline Denton Caroline Nursing Home 8. Date of Birth (Month, Day, Year) March 17, 1926 9. Birthplace (State or Foreign Country)
Pennsylvania 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 **X** M 2 □ F Months Director 215-26-7315 86 Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 USA 701 Market Street Apt. A Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Yes 2 □ No If Aes, Give þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HS Grad S<u>erviceman</u> Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ int of Health and Menta t: If item 27 is marked or other traumatic e Elsie Mae Hatfield Randall Henry Knox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edwina B. Knox/wife 520 Kerr Ave., Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1st State Cremation Center: 8/15/12 Georgetown, Delaware 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Moore Funeral Home, P.A. Dande 12 South 2nd Street Denton, Maryaldn 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SCVdz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of; attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 4 Pregnant After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown COPD 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 4 Homicide within 24 hours after der

To the Funeral Director

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check The Dasis of examination and the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

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ature and title of certifier

melinda Butar

AUG 1 5 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

MI

22. Registrar's Signature

D0053255

3683 Chaptank Rd Preston MD 21655

2012

AS J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 27519 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Keeler Rose Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany WMHS-RMC If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country D.C. **Funeral** Mar 13, 1951 **Director** 213-56-9387 1 □ M 2 🗶 F 61 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Allegany Rawlings 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21557 USA P.O. Box 161 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Centre St. United Methodist Church administrative assistant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Virginia Jollisse Charles Oliver Curtin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau William Keeler MD 21557 P.O. Box 161 husband Rawlings 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Scarpelli Funeral Home, P.A 1 Burial 2 Xremation 3 Removal from State 8/19/2012 MD Cresaptown Donation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA of Funera, Service 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of Be Completed by Physician/Medical

Ph\_sician/ Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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with the Maryland

Page 1 and 2 should be filed within 72 hours after death

and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-tra 124 hours after death.

Funeral Director: A sletely filled in by the fi

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Medical Certificate: within 2
To the F
complet State Registrar

resulting in death) Last	Due to (or as a consequence of):  d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify) 9  Unknown		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	
25. Was case referred to medical	26. Place of Death (Che	ck only one)	1000 E
examiner? 1  Yes 2 No	Hospital: Other:	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at	28d. Describe how init	irv occurred

						autopsy performed? 1 \(\sum \) Yes 2 \(\sum \) No	prior to completion of cause of death?  1  Yes 2 No				
Was case referred to medical examiner?			20000								
1 ☐ Yes 2 ☐ No	Hos	Hospital:  1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28a. Date of injury (Month, Day, Year)	28b. Time of injury -	М	28c. Injury at work? 1  Yes 2  No	28d. Describe how injury oc	courred				
3 Suicide 6 Could not 4 Homicide determined		28e. Place of Injury - At he building, etc. (Specify		t, fact	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,					
- Contident 1 7 Contident Die		en. To the book of me. Imper	January Jacobs as	01111100	lat the time date and place	and due to the source/o) and i	mennor as stated				

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License numbe 29b. Signature 29d. Date signed (Month, Day, Year

ess of person who completed cause of death (Item 23a) (Type, Print)

MD.12502 Willowbrook Rd. Ste.300 Cumberland, MD also Alida

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			For State Registrar	State of	Maryland		tificate d				giene Reg. No.	12	27520
	Physicia	an/	1. Decedent's Name (First, Middle, La	ast)				-		2. Date of Dea	ath	Voor	3. Time of Death
1	Medi	cal	CARROLL 4a. Facility Name (if not institution, given	ro atmost and aumit	205	LINK			( D )	Augus		2012	8:42 AM
	Exami		FREDERICK ME	MORIAL	HOSPI		4b. City, Tow FRE	DERIC		Labar (B)	FRI	nty of Death	
	Funeral Director			1 □ M 2 🔏 F	7. Age (In yrs. Ias 76	Yrs.		ays Hours		8. Date of Bird (Month, Da Aug • 29 ,	1935	West	place (State or Foreign try) Virginia
	Maryland 28a-f shov tified at	rector	Maryland Prince	George's		Town or Local							10d. Inside City Limits 1  Yes 2 No
	with the is 23a or 3	Funeral Director	10e. Street and Number 12600 Calvert Hi	lls Drive	9		10f. Zip Co				10g. Citizen d Unite	of What Cour d Stat	
9036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  **The Maryland State of the than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 [X]Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes 3 If Yes, Give Year or Date	ces? 2 🕅 No		/as Decedent Yes, specify 0 ☐ Yes 2 X			cify Yes or No- Rican, etc.)		ace - Americ lack, White,	
15-0	72 hou n "natu ledica	Completed	15. Decedent's (Specify only highest g			(Give k	ent's Usual Od ind of work do	ne durina m	ost of worki	ng	16b. Kind of	Business/In	dustry
212	within giene. er thai		Elementary/Secondary (0-12)	College (1-4	1 or 5+)		NOT use reti istrat	/	sista	nt	Univ.	of Ma	aryland
Baltimore, Maryland 21215-0036	d be filed Mental Hy, arked oth	To Be	17. Father's Name (First, Middle, Last) Bill Fudge							e (First, Middle, adys Ba		me)	
Man	nd 2 shoul ealth and I m 27 is ma	2	19a. Informant's Name/Relationship ( Kenneth E. Linki			19b. Mailin 1540	g Address (Str B <b>riar</b>	eet and Num Meadow	ber or Rura Driv	Route Nymber e Colum	ibus, 0	State, Zip ( hio	43235
imore	a 0 = =		20a. Method of Disposition  1 X Burial 2 Cremation 3 [ 4 Donation 5 Other (Spec		tate ce	metery, crem	ition (Name of atory or other <b>terans</b> (	place)		2012	20c. Location		own, State Maryland
Balt	permit. Page Department Important: any injury o		21. Signature of Funeral Service Licer	Bogu	all	₽6 44	næled⊲V 00 Pow	der Mi	wardt 11 Ro	Funera ad Belt	l Home sville	, PA , Mary	land 20705
	Ph_sician/ Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eac	h line.	onio		dying, such a	as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediat	b. Re	30 Pa	PORU	1 1	a; Cu	re		7	7	1-10 days
	executed an and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	r as a conseque	ence of):	nds>	poli	gnei	Ropa.	tuy /	4	1-10 days
09289		Medical		d					CERTIFIC	ATION APPROVE	BY MEDICAK	EXAMINER	· Ma
Box	death ne atte ed for	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		rth 2  Fetal ant at time of de	death 3	Ectopic pregr Other (specify					Date of delive	ery Day Year
ls, P.O.	uires that the signed by the	ed by P	Part II. Other significant conditions	_	ath but not resul	Iting in the ur	derlying cause	e given in Pa	rt I.	23e. Did to	V		ne cause of death?
Division of Vital Records,	The law ate has page 2	Complete	- Arute x	Edney	inj	ury				24a. Was a autop perfor	sy	. Were autor prior to cor death? 1 \(\sum \) Yes	osy findings available mpletion of cause of
ital	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				3. Place of De	eath (Check				
ν of V	Attending Physician: or death. ector: After this certific by the funeral director,	ate: To	1 X Yes · <del>2                                  </del>	1 2 In 28a. Date of	patient 2  E injury 2 Day, Year)	R/Outpatient 28b. Time of injury	28c. li	njury at vork?	2	me 5 Resid			)
ivisior	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not to determined	pe 28e. Place of	f Injury - At hom , etc. <i>(Specify)</i>	ne, farm, stree		Yes 2	-	28f. Location (S City or Town		ber or Rural	Route Number,
Ω	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check 2 Medical Exam	rsician: To the bes	of examination a	and/or investig	gation, in my o	oinion, death	occurred at	the time, date ar	nd place, and d	ue to the cau	use(s) and manner stated.
	To the within To the comp		only one) 3/ Qertiffing Nur 29b. Signature and yttle of certifier	ye Practitioner: 1	o the best of my	r knowledge, t		ense number	iate and pla		29d. Date sign		
	,		30. Name and address of person who	completed cause	of death (Item 2	(Type, Pr	int)	JU W	U77-	ST 1	Tuga	シャ	21701
	Star Registra		31. Date filed (Month, Day, Year)  AUG 28 2	012 32. 69	istrar's Signatur	· ~ .	700	TOW	ITY	317	reour	ich ,	MID
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrative No. 13/12; BWW, McCo  Certificate of Death  Reg. No. 2012 2752
			1 - State Registra MEND#7perFH, 8/13/12; BWW, McCo Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
П	Physicia Medic		Agnes L. Lawson 08/05/2012 2:22 p <sup>M</sup>
in	Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
المسبها	ž.		Washington Adventist Hospital Takoma Park Montgomery
	Funeral Director		5. Social Security Number 220 – 11 – 2729   1 $\square$ M 2 $\square$ F   7. Age (In yrs. last birthday)   1 $\square$ M 2 $\square$ F   93 Yrs.   1 $\square$ M 2 $\square$ F   93 Yrs.   1 $\square$ M 2 $\square$ F   94 $\square$ 93 Yrs.   1 $\square$ M 2 $\square$ F   94 $\square$ 94 $\square$ 95   1 $\square$ M 2 $\square$ F   95 $\square$ Months   Days   Hours   Min.   05 / 14 / 1919   9. Birthplace (State or Foreign Country)   9. Birthplace (State or Foreign Country)   1 $\square$ M 2 $\square$ F   1 $\square$ M 2 $\square$ Months   Days   Hours   Min.   05 / 14 / 1919   Ghana
	land shov	ţō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary 28a-1 ootifie	irec	MD Prince Georges Beltsville 1 x Yes 2 \( \text{No} \)
	h with the ns 23a or nust be r	<b>Funeral Director</b>	10e. Street and Number10f. Zip Code10g. Citizen of What Country?8012 Alloway Lane20705Ghana
9003	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by Fu	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1  Yes 2  No Specify:  14. Race - American Indian, Black, White, etc.  1  Yes 2  No Specify:
Baltimore, Maryland 21215-0036	vithin 72 houliene.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  Business woman  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Business woman  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16c. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  Self-employed
land 2	d be filed w Aental Hyg Irked othe Iic event,	To Be	17. Father's Name (First, Middle, Last)  Joseph Lawson  18. Mother's Name (First, Middle, Maiden Surname)  Rebecca Dickson
, Mary	id 2 should salth and N 27 is me er trauma		19a. Informant's Name/Relationship (Type, Print)  Edward Quartey-son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8012 Alloway Lane Beltsville, MD 20705
imore	permit. Page 1 an Department of He Important: If iten any injury or oth		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Family Cemetery 9/20/12  Accra, Ghana
Balti	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home 3447 14th St., NW Washington, DC 20010
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  ACUTE MYO CARD AL INFARCTION
	Medical Examiner	J.	resulting in death)  Due to (or as a consequence of):  Sequentially flet conditions,
	outed and	xamine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events c.
09	ate be executed physician and the burial to	dical Examiner	resulting in death) Last  Due to (or as a consequence of):  d
P.O. Box 687	death certific le attending   ed for use as	Physician/Me	FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   1
ds, P.O	anec 3nec	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown
Division of Vital Records,	uing Physician: The law re n. After this certificate has be funeral director, page 2 sh	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 \( \text{ Yes} \) 2 \( \text{ No} \) No
ita	sician certifi irecto	Be c	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:
n of V	iding Phy th. After this funeral d	cate: To	27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DoA  Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 1 Natural 5 Pending 2 Accident Investigation N M I Vest 2 No
Divisio	al or Attendir s after death. Il Director: Af ed in by the fu	Certificate:	3 Suicide 6 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1
	with to be a sound to be a sou		29b. Signature and title of certifier  29c. License number  DY0324  29d. Date signed (Month, Day, Year)  AUGUST 5, 3012
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRY JODRIE, MD, FACEP 7600 CARRELL AVONUE, TAKOMA PARK, MARYLAND
	Stat Registra	e ir	31. Date filed (Month, Day, Year) AUG 13 2012  32. Registrar's Signature A. Saules

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please <sup>-</sup>	Type or Print in B						_	e.
		T State	State of Maryland		artment of I <i>tificate of L</i>		d Mental Hy	_		2 27522
		Registrar  1. Decedent's Name (First, Middle, Last)		061	incate or i	Jean	2. Date of De		201	3. Time of Death
Physicia Medi		John Lav	<i>lerty</i>				Month	06	C 41 1 42	2000
Exami		4a. Facility Name (if not institution, give so ANNE ARUNDEL MEDIC.			4b. City, Town, o		eath		County of De	
Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year Months Days	If Under 24 I		rth	9. E	Birthplace (State or Foreign
Director	ı	Usual Residence of Decedent	<b>X</b> м 2 □ F 80	Yrs.	Months Days	Hours	/lin. (Month, Di 1/31/1			Country) IAINE
Maryland 28a-f show otified at	ţoţ	10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City Limits
e Mary r 28a-i notifie	Director	MARYLAND ANNE ARU	NDEL ANNA	POLIS	Lieu et a d					1 X Yes 2 □ No
with the 23a or st be n		10e. Street and Number 325 RIVERVIEW TRAI	т.		10f. Zip Code 21401				izen of What of TED ST	
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V		lispanic Origin?	(Specify Yes or No-		14. Race - An	merican Indian,
s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	d by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give		Yes 2 XNo		erto riloan, etc.)		Black, Wh	
72 hours after n "natural", or fledical Exami	lete	15. Decedent's Edu			lent's Usual Occup				ind of Busines	ITE ss/Industry
within 72 giene. <b>ier than</b> " <b>i, the Mec</b>	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	kind of work done of NOT use retired)	during most of t	working	1		•
filed wit al Hygie d other event, th	Be	12 17. Father's Name (First, Middle, Last)	5+	MANAG	ER	18. Mother's	Name (First, Middle		INEERI Surname)	NG
be en i	2	KYLE LAVERTY					LAFFIN	,		
should h and M 7 is mar traumat		19a. Informant's Name/Relationship (Typ)	e, Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Numbe	er, City or	Town, State, .	Zip Code)
and 2 f Healt item 2		NORMA HARRIET LAVE 20a. Method of Disposition	20b, Pla	ace of Dispos	sition (Name of		ANNAPOLI Date			or Town, State
Page nent of		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State CHES	metery, crem AREAK	E CREMAT.	ION 8/	8/2012	l .	,	LLE, MD
permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service Licensee					ASTING TE AM CREMAT ANNAPOL			•
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Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque							1
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rted d ansit	Examiner	Cause (Disease or injury	CARONIC C	PASTRE	arve P	oumos	AMY 10154	458		
executed ian and urial-transi	I I	that initiated events c resulting in death) Last	Due to (or as a conseque	nce of):				, , ,		
Attending Physician: The law requires that the death certificate be reath.  sctor. After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	d								
eath certifica attending pl	in/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnand	ру	15.				23d. Date of c	delivery
death he atte ed for	sicia	in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live Birth 2 Fetal of 4 Pregnant at time of de		Other (specify)	ЭУ			Month	Day Year
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ttendir death. ctor: Af y the fu	Certificate:	1 Autural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No				
al or Atteno s after death Director: d d in by the	- 1	4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	et, factory, office		28f. Location ( City or Tox			Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	sian: To the best of my knowleder: On the basis of examination a	dge, death o	ccurred at the time	e, date and place	ce, and due to the c	ause(s) ar	nd manner as	stated.
the Fithin 24 the Formplet	Me		Practitioner: To the best of my		death occurred at t	he time, date an		the cause(	(s) and manner	r as stated.
<b>≒≥</b> ₩8		) Prog	re		29c. License	623L	19			nth, Day, Year)
しらかり		30. Name and address of person who cor	npleted cause of death (Item 2	3a) (Type, P	rint)					
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Sta	te	31. Date filed (Monito DE YOR) 201	32. Degistrar's Signatur	4 1						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY J. LEITHREN 2012 KELLY 4:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CECIL ELKTON 8 CARRYBACK DRIVE If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months **Director** 222-40-2108 55 1 □ M 2 🛚 F JULY 24, 1957 DELAWARE Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MDCECIL ELKTON 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral UNITED STATES 8 CARRYBACK DRIVE 21921 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **HEALTHCARE**  ${ t PHLEBOTOMIST}$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MAY SPRINGER ROBERT ARMSTRONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARRYBACK DRIVE ELKTON, MD 21921 DAVID A. LEITHREN/HUSBAND Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of X Burial 2 Cremation IMMACITLATE CONCEPTION CEMETERY ELKTON, MD 4 Donation 5 Other (See 22. Name and Address of Facility SPICER-MULLIKIN FH ignature of Fur 1000 N DUPONT PKY NEW CASTLE, DE 19720 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or compli-shock, or heart failure. List only one Approximate suse on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as ) consequence of Examiner Sequentially list conditions. Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): היים נואו certificate has been signed by the attending physician funeral director, page 2 should be detached for נואה אים באים Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After work? Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the cause(s) and manner stated. 29a. Certifie only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William J. Lee, Sr. Aug 2012 3:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1106 Busic Church Rd. Marydel Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Months 1 🔀 M 2 🗆 F 10/7/1943 North Carolina 218-42-4590 Director 68 Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Caroline Marydel 10e. Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1106 Busic Church Rd. 21649 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Never Married 2 🕅 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 🗌 Yes 2 💢 No Specify: "natural", Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Plumber <u>Lockheed Martin</u> permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) should be file h and Mental H is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ James Bright Lee Lena Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Ann Lee/wife 1106 Busic Church Rd., Marydel MD 21649 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCtr. 8/13/2012 Cambridge, MD Signature of Funeral Service Dicensee 22. Name and Address of Facility Mid Shore Cremation Center ah Box 1464, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNGCANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE 24a. Was an autopsy 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Investigation Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗆

29b. Signature and tit

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 448241

D CHESTERTOWN, MD 21620

for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ALICE DOLORES SMYDER LIVINGSTON Medical 4a. Facility Name (if not institution, give street and number)

CITIZEN CARE NURSING F 4b. City, Town, or Location of Death
HARVE OF GRACE 4c. County of Death
HARFORD **Examiner** HOME 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Hours 216-09-6880 99 **Director** Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City, Town or Location Director MD. Harford Fallston 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral with 23a 2406 Watervale Road 21047 United States items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ō Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည P. Joseph Snyder Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 law 2406 Watervale Rd. Fallston, June S. Livingston/Dau-in-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 24, 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 John's Cemetery Hydes, 21. Signature of Funeral Service License 22. Name and Address of Facility Kurtz & Son Funeral E.G. Jarre Home. P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators. shock, or heart failure. List only one cause on each Immediate Cause (Final En um us Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to r as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant P.O. Box 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 🗌 No page 2 should be detached g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24 anavysin has Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only or examiner? Hospital: IVINGESTON 2 No ၉ 1 🗀 Inpatient 2 🗆 ER/Outpatient 3 4 Nursing Home 5 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Model	lan ;	KW/K-	Hon					lle,	Ma	ryland		
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		1 🗌 Inpatient 2		□ DOA Other	r: 4 Nursing I	lome 5 □ R	esidence	6 🗆 Oth	er (Specit	ý)		
Pending Investigation	n (	Date of injury Month, Day, Year)	28b. Time of injury	28c. Injury work? 1 1 1		28d. Describ	e how inju	iry occuri	red			
Could not be determined	28e. F	lace of Injury - At I uilding, etc. (Speci	nome, farm, street, f fy)	actory, office			8f. Location (Street and Number or Rural Route Number, City or Town, State)					
edical Exam	iner: On the	basis of examinati	vledge, death occur on and/or investigation ny knowledge, death	on, in my opinior	n, death occurred	at the time, da	te and plac	e, and du	e to the ca	ause(s) and manner	state	
f certifier	Mn-			29c. License D46	number 412—		29d. D	ate sign	d (Month,	Day, Year)		
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2012	Zenewi	2. Registra 's Sign	dure de la									
			ORIGINAL									

27525

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Marvland

20/2

Black, White, etc.

Banking

White

Lightner

Maryland

Maryland

0625 M

State Registrar Natural

Accident

Suicide

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 2 8 2012

SUPSIM

5 Pending

Investigation 6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours after deat To the Funeral Director:

the

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 27526

		Registrar					Certifi	cate of	Dea	ath				Reg. No	). 			102
Physic edical Exam				Month Day Year									3. Time of 0131					
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Funera Directo		5. Social Security N		6. Sex		7. Age (I	n yrs. last b	•	If Un	ider 1 Year	If Unde	Min.	7		//DD/YYYY)	Foreigi	n	ate or
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Any		Usual Residence of 10a. State	Decedent 10b. County			110	c. City, Tow	n or Locati	on				-				10d, Insid	le City Limits
<b>E</b> .	_	MD	Ca	lve	rt		•			Repu	ıhli	ic					1 X Ye	s 2 No
faryland 28a-f shov	Director	10e. Street and Nur		LIVC	.1 C					ip Code	<u> </u>			10g. C	tizen of Wha	at Coun	try?	
215-0036  be filed within 72 hours after death with the Maryland mtal Hygiene. riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ä	3230 Hi	llcre	st	Stre	et		20676					USA					
h with ms 23 be no	Funeral	11. Marital Status	🗀 .		12. Was Dec		er in U.S.			dent of Hispa cify Cuban, I			ecify Yes or	No-	14. Race - White,		can Indian,	Black,
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5-00 led wit Hygien 1 other	၂ မ	17. Father's Name	(First, Middle	, Last)	•			TIUC	.17				(First, Middle	e, Maide		HCI	ete	
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TOFE, ages 1 and of Heat If ite other tr		1 Burial 2		n 3 🗌	Removal fr	rom State	crem	atory or oth	er plac	e)				200	. Location - t	city or	Iown, Stat	9
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Baltimore permit. Pages 1 a Department of Ho Important: If it		21. Signature of Fu								nd Address o		IV.	_		ood I		., P	.A.
Physician	_	23a. Part I. Enter th	e disease, or	complic	ations that c	aused the	death. Do	PC not enter th	Be mode	ox 43	O ,	Dun ardiac or	kirk,	MD	20°	754	Approxin	nate Interval
/Medica		failure. List on	ly one cause	on each	line.					,					,		Between	n Onset and Death
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Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	교 표			d														
D, be ex sician	n/Medical	UNPENDED			AMENDED													
68760, certificate be nding physic se as the bur	N Z	IF FEMALE: 23b. Was decedent	pregnant in th		23c. If yes, 1 Live b			-	al doet	h 3	Ectopic	: pregnan	)CV	23	3d. Date of d Month	-	ay	Year
x 68 h certi tendin use a	Cial	past 12 months			_		e of death	2 Fet	er (Sp		Lotopio	program	.5,		WOTHER		u,	Tour
Box e death c the atten ed for us	Physicia	1 Yes 2 N			9 Unkn													
P.O. Box 68 ss that the death certi gned by the attending or detached for use as	by P	Part II. Other signif	ficant condit	ions co	ontributing to	o death bu	ıt not resulti	ing in the ur	nderlyir	ng cause giv	en in Pa	rt I.	_		use contrib	_		
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F 3 . ~ 2	i o	1 Natural	5 Pend	dina	28a. Date (Month Aug 11,	Day Year)		05 hrs	ijui y	1 Ye		le le			er of a m		ehicle r	oll over
Division tal or Attendir rs after death. al Director: A	icat	2 Accident	Inve	stigation	28e. Plac	e of Injury	- At home.	farm. stree	t. factor	ry, office buil			28f. Location	(Street	and Number	or Rur	al Route N	lumber, City
Div ital or irs after ral Div	Certification:	3 Suicide 4 Homicide		d not be rmined			ved Road		,	,,		R	or Town Rear of 906	, State) Costly	Way, Princ	ce Fred	derick, MI	D
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	١.	20a Codifies	CertifyIng P	hysician	: To the bes	st of my kr	nowledge, de	eath occurr	ed at th	ne time, date	and pla							
Fo the vithin Fo the	Medical	one) 2	Medical Exa		n the basis on the manner s		ation and/or	investigati				curred at	the time, da	te and p	ace, and du	e to the	cause(s)	
	×	29b. Signature and	title of certifie	er	1	1			25	9c. License r					Date signed		th, Day,Ye	ar)
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zw 5		30. Name and addre			npleted caus ant Medic				altim	ore Stree	t Ralti	more	MD 2122	3				
	State	31. Date filed (Mont.	h. Dav.Year)		32. R	gistrar's	Signature a			1	ı, paili							
Regi			AUG T	4 20	12 /2	enewa	1 1.	Ma	de	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of Maryland /	Departmen	t of Health and	Mental Hyg	jiene	07507		
1	State     Registrar		Certificate	of Death	F	Reg. No. 2012	27527		
	1. Decedent's Name (First, Middle, Last)				Date of Dea     Month		3. Time of Death		
Physician/ Medical _	<u> </u>	rtin			August	1	10:50 ам		
	ta. Facility Name (if not institution, give str 11717 Devilwood Dri		_ ′′	Town, or Location of Deat Oma C	h	4c. County of Death Montgo			
rulleral	5. Social Security Number 6. Sex 1 $\square$	7. Age (In yrs. last bit	rthday) If Under Yrs. Months	1 Year If Under 24 Hrs Days Hours Min.		9. Birtl	nplace (State or Foreign intry) NY		
	Usual Residence of Decedent	140.00.7					10d. Inside City Limits		
ryland -f she ied at	10a. State 10b. County		wn or Location				1 Yes 2 XNo		
r 28a notif	MD Montgo	mery Po	otomac 10f, Zip	Code		10g. Citizen of What Co			
beath with the Maryland terms 23a or 28a-f shours the notified at the rmust be notified at Funeral Director	11717 Devilwood Dri	ve		20854		USA			
- 5 FB -	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, spec	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert 2 Ano Specify:	pecify Yes or No- o Rican, etc.)	Black, White	lace - American Indian, Ilack, White, etc. White		
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hyglene. 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		a. Decedent's Usua (Give kind of won life. DO NOT use Clerical	k done during most of wo	rking	Non-Profit			
land 2 be filed v lental Hyg rked othe tic event,	17. Father's Name (First, Middle, Last)  Cyrus Anthony Mar	tin			me (First, Middle, I Catherin				
Mary 2 should th and M 27 is man traumat	19a. Informant's Name/Relationship (Type Stephen A. Martin/B		•	(Street and Number or Ru					
Baltimore, oermit. Page 1 and Department of Heal Important: If item; any injury or other pnee.	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	20b. Place cemet	of Disposition (Nam tery, crematory or of	ne of ther place) Δ1	Date 11, 2012	20c. Location - City or	Town, State		
Baltimore Baltimore permit. Page 1 a Department of H Important: If ite any injury or oft	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		politan C	rematory Address of Facility S J. Collins versity Blvd	_	Alexandria Home Inc.			
m eggrap	23a. Part 1. Enter the disease, or complic	Actions that caused the death. Do					Approximate		
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Examiner		Due to (or as a consequence	e of):						
xecuted n and transit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence	e of):						
a dia e	that initiated events resulting in death) Last	Due to (or as a consequence	∋ of):						
	d.								
BOX death ne atte ed for a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	oregnancy ecify)		23d. Date of delivery Month Day Year				
s that the gned by the detach	Part II. Other significant conditions cont	ributing to death but not resulting	g in the underlying o	ause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?		
dS, quires and be	CVA				1 🗆 ነ	∕es 2 □ No 3 □ Pr	obably 4 Kunknown		
Records, The law requires cate has been sign page 2 should be					24a. Was a autop perfor 1  Yes	sy prior to death?	opsy findings available completion of cause of		
Vital Re ysician: The is certificate director, pag	25. Was case referred to medical examiner?			26. Place of Death (Che					
hysic his ce I dire	1 ☐ Yes 2X No	spital: 1  Inpatient 2 ER/C		OA Other: 4 \( \sum \) Nursing I	Home 5 Resid	ence 6 Other (Speci	fy)		
on of V ding Phys th. After this funeral din cate: To	27. Manner of Death  1X Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury 28b. (Month, Day, Year)	, Time of 2: injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe he	ow injury occurred			
Division of Vital Records, pital or Attending Physician: The law requires ours after death. eral Director: After this certificate has been signed in by the funeral director, page 2 should be cal Certificate: To Be Completed	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, 1 building, etc. (Specify)	, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	(Check 2 Medical Examine	ian: To the best of my knowledge r: On the basis of examination and Practioner: To the best of my know	/or investigation, in r	ny opinion, death occurred	at the time, date ar	nd place, and due to the o	ause(s) and manner stated.		
To the Hos within 24 h To the Fun completed	29b. Signature and title of certifier			License number		29d. Date signed (Month			
6	) CIE VV			D37142	A	August 10,	2012		
Y	30. Name and address of person who con G. Coleman, MD 1	npleted cause of death (Item 23a) 355 Piccard Dri	(Type, Print)	, Rockville	, MD 20850	)			
State Registrar	31. Date filed (Month, Day, Year)  AUG 13 2012								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State	of Ma	rylan	d / Depa	artme	nt of H	lealth	and N	1ental Hy	gien	ean	12	27	52B
			T _ State Registrar					Cer	tificat	e of E	Death		_	Reg. N	. Z. U	1 2	41	320
	Physicia Medi		Decedent's Name (First, N     Richard	A •	•	Mahor	a, J:	r.					2. Date of De Month August		ay 2012	(ear	3. Time o	
	Examir		4a. Facility Name (if not institu	_		mber)					Location			4	c. County of	Death		
			4810 Delawar								Parl				P.G.			
	Funeral Director		5. Social Security Number 216–90–1873		х ≦м 2 □ F	7. Age (	(In yrs. la	st birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Coun		or Foreign
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with	s 23e	eral	4810 Delawa	ce St	reet					207	40				SA	at oour	uy:	
leath	tems er m	Funeral Director	11. Marital Status		12. Was Dec		er in U.S.		as Dece	ent of His	spanic Ori	igin? (Spe	cify Yes or No-		14. Race -	Americ	an Indian.	
5-UU36 Pours after of	rel", or i	ρ	1 ☐ Never Married 2 🖾 3 ☐ Widowed 4 ☐ Divo		Armed Fe 1 ☐ Yes If Yes, Gi Year or D	2 ဩ No ve	0				n, Mexicai Specify		Rićan, etc.)			White,	etc.	
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N E	√ygie ther nt, th	Be	17. Father's Name (First, Midd	(a 1 = a4)				Mall	. Car	rier					SPS			
Be file	ental I ked o c eve	P	Richard A. M.	. ,	Sr.								(First, Middle, Ramie	Maiden	Surname)			
Pino Pino	nd Me marl meti		19a. Informant's Name/Relati					10h Mailin	- Add	/C4								
e, Misand 2 sh	Health er em 27 is ther trau		Karen Mahon/					4810	Dela	ware	Stre	er or Hura eet,	Route Numbe	r, City o	rk, M	e, zip C D 20	740	
Page 1	Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-1 shov with jury or other traumetic event, the <u>Medical Examiner must be notified at once.</u>		1 🛣 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	ion 3 🔲 I er (Specify)	Removal fron		ce	ace of Dispos metery, crem Linco	atory or c	ther place	-	Aug.	14, 012		ocation - Ci			
Dan	Depart Import any Inj once,		21. Signature of Funeral Serv	e License	eener	1		22. Fr	Name ar	d Address	s of Facilit	ins	Funeral	Но	me In	2;	, MD	20001
			23a. Part 1. Enter the disease	, or compl	ications that	caused th	ne death.	. Do not enter	the mod	of dying	, such as	cardiac or	r respiratory arr	est,	er Sp	Cine	Approxima	20901 ate
	ysician/ Medical		shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	st only on	Live												Interval Be Onset and 2 mo	tween Death
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equire	been signe should be (				-					-	_		1 🗆 🗅	/es 2	□ No 3 l	Prob	ably 4 🖾	Unknown
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n 24 hou	To the Funeral Director. Af	Medical	(Uneck 2 L Medic	ai Examine	er: On the bas	sis of exam	nination a	and/or investic	iation, in r	ny apinian	i death oc	curred at t	d due to the car he time, date ar e, and due to th	nd place	and due to	the cour	ole) and me	anner stated.
_ Tot I	<b>70</b>		29b. Signature and title of cert						29c.	License r	number		2	29d. Da	te signed (M	onth, D	ay, Year)	
,			30. Name and address of personal Jeanny Arago							а Атт	anua	<b>∄1</b> .	200, Wa	a ch d	notes	D.	2000	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 6:50 AM Milbourne Stanley August 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospi tal Crisfield MeCready Somerset Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months Days 91 218-03-3283 Yrs. Director Maryland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I fiems 21 is anacked other than "natural", or items 23a or 28a-f sho minortant: I fiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Crisfield Mary land Somer se 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. Rd 21817 Walter Jones Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1  $\square$  Never Married 2  $\square$  Married 1944 - 46 Baltimore, Maryland 21215-0036 1 ☐ Yes 2' No Specify: Specify: Black 3 ¥ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)

7th grade College (1-4 or 5+) ity of Cristield Sanitation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Milbourne Sr Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 178 Somers Carol Ann Jones - great Niece Cove Cristield. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 20/12 4 Donation 5 Other (Specify) Hurlock Veterans Cemetery 21. Signature of Juneral Service Licensee E. Ward F.H. 22. Name and Address of Facility nthony Hampden Princess Anne, MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onact and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due o (or as a consequence of) Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Proystician: The Within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KINS 207

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 27530 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 18 2 ď 1 2 11:05A M HAROLD MCCLURE KASH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES TA PLATA 1028 WILTSHIRE DRIVE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** JULY 5, 1940 1 🛛 M 2 🗌 F Months Days Hours KENTUCKY Yrs **Director** 236-60-8676 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director LA PLATA 1 🗗 Yes 2 □ No CHARLES MD ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral U. Α. 1028 WILTSHIRE DRIVE 20646 S. items 2 death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 K Married 1√√Yes 2 □ No If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed Year or Dates. 58-WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. NAT'L. STONE, SAND within 7 Elementary/Seconday (0-12) College (1-4 or 5+) the GRAVEL ASSOC. MEMBERSHIP VICE PRES. OF 12 Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည TENA NOBLE NAVANE MCCLURE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If Item 27 is any injury or other trau once, 20646 YVONNE MCCLURE/SPOUSE 1028 WILTSHIRE DRIVE, LA PLATA, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 8-24-2012 CHELTENHAM, MD VETS. CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licen MD20646 5635 WASHINGTON AVE., LA PLATA, ory M00641 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 8 -Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Besidence 6 Other (Specify) this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury death. 1 Yes 2 No hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide City or Town, State) To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 24 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Yea

AUG 2 8 2012

Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G931 Department of Health and Mental Hygiene 1 - State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0803AN Maffley Tobias Richard Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Nov 17, 1964 MD 215-86-2495 Usual Residence of Deceden Director 1 **X** M 2  $\square$  F 47 10c. City, Town or Location 10d. Inside City Limits 10a. State at Director must be notified MD Allegany Cumberland 28a-f 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 21502 USA 235 Paca Street Apt. 806 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural" 3 Widowed 4 Divorced white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n/a disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of ir traumatic ever ၉ Margaret Loretta Harden John Lewis Maffley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
C72 Climbotope Creek pp. Clearville PA 15535 19a. Informant's Name/Relationship (Type, Print) 873 Flintstone Creek RD. Clearville it of Health a: If item 27 i Barbara Beck sister other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Kremation 3 Removal from State or Department of Important: If any injury or once. 8/20/2012 MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA ignatu of Fun ral Servi 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate cause (Final disease cause (Final disease cause of the Approximate Interval Between Onset and Death Ph sician/ Hemptoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death detached 1 Yes 2 L P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco-use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🎖 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Morth, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☑ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Fell Accident
Suicide
Homicide Investigation filled in by the 6 Could not be Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
285 CACA ST CUMBERN NO determined STRER Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

340

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
6 25 KFNT NVE STE 306 CUMBERUAND MD

State <sup>31</sup> Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 8 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood Mandrin Hospice House If Under 1 Year | If Under 24 Hrs. Social Security Number 213-69-0025 Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 69 Director 1 M 2 TxF 7/12/1943 Philippines Usual Residence of Dece show 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director Annapolis Anne Arundel Maryland 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Philippines 21403 111 Steffey Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married ☐ Yes 2 🔀 No Specify: Asian Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Caregiver e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Steffey Drive, Annapolis, MD 21403 19a. Informant's Name/Relationship (Type, Print) Antonio Nieve - Husband Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or otl 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Baltimore Crematory 8/8/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ERVICAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No 1 Yes 2 the page 2 should be detached a 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ᅆ 4 ☐ Nursing Home 5 ☐ Residence 6 KOther (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No М 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D003658\ 445 Defensi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERSH 31. Date filed (Month, Day, Year) 32. Re State

DHMH 17 Rev 06-2011

Registrar

**AUG 09** 

State of Maryland / Department of Health and Mental Hygiene 2 0 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Louise Perry Joan Aug. 12. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4335 Blossom Lane Prince Frederick 5. Social Security Number 8. Date of Birth (Month, Day, Yea, May 2. 1 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 M 2 XF Hours 579-36-4157 Director 81 Yrs Ĩ931 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director be notified Prince Frederick Maryland Calvert ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20678 4335 Blossom Lane USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced Specify Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "n Prince George's Co. Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Helen L. Fairfax ပ Arthur D. Stanley, Jr. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code item 27 4335 Blossom Lane, Prince Frederick, MD 20678 Deborah Bondurant - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Aug. Date 6. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sothern Mem. Gardens 2012 Dunkirk, MD 21. Signature of Fuperal Service License 22. Name and Address of Facility 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 manda M. Ergler 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical 68760 as the nse 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Pregnant at time of death 1 Yes 2 kg be detached Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES Records. 1 Yes 2 No 3 Probably 4 Unknown HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy or Attending Physician: The lafter death. performe certificate Yes 2 XN Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo 1 Yes Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours al To the Funeral Di

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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3. Time of Death

Calvert

9. Birthplace (State or Foreign

Washington DC

10d. Inside City Limits

White

Approximate Interval Between

Onset and Death

Day

2 No

2012

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Year

1 Yes 2XXNo

State

Medical

29a. Certifier

29b. Signative

and title of certifie

30. Name and address of person KLSON

31. Date filed (Month, Day, Registrar

who completed cause of death (Item 23a) (Type, Print)
BENJERS, 9131 PISCAT AWAY

1 Secrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8 - 08 - 2012 Year Physician/ 6:30 AM Lawrence Pugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 1 🗶 M 2 🗆 F 252-84-3708 07-22-1950 62 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho within 72 hours after death with the Maryland Director 1 Yes 2 X No Suitland MD P.G. 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral U.S. 20746 4110 Skyline Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 7 0

If Yes, Give 1970 Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Black Specify. 3 Widowed 4 Divorced Completed Year or Dates. 1970 event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Printing Printing Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ pe Annie P. Pugh Nathaniel Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m Department of Health an Important. If item 27 is any injury or other trees. 4110 Skyline Dr./Suitland, MD 20746 Maria Pugh / Wife altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8-14-2012 Brentwood, MD 4 Donation 5 Other (Specify) Ft. Loncoln Cem. 22. Name and Address of Facility The House Of Williams Funeral 21. Signature of Funeral Service Licensee E. W seums MO1182 & Crem Srvcs/814 Upshur St, NW/Wash, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ician and burial transit that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Records. been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed' 1 Yes 2 No 1 Yes 2 Wo Division of Vital filled in by the funeral director, Be ( 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director, After tompletely filled in by the funeral iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08-08-12

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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29b. Signature and title of certifier  O.C.M.E. August 9, 2012  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Hosp 14 hot Funer ely fil		29a. Certifier	Cortifidad	Physician: To	the best of r	ny knowle	dge, death occu	rred at the ti	me, date and p	olace, and	I due to the ca	use(s) ar	nd manner	as stated	001100(5)	
29b. Signature and title of certifier  O.C.M.E. August 9, 2012  30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	thin 2 the 1 the 1	dica		=	aminer: On the	basis of exa	amination	and/or investiga	ation, in my o	pinion, death o	occurred a	at the time, dat	e and pl	ace, and d	lue to the	cause(s)	
30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		Me	29b. Signature ar	nd title of certi		// (	1		29c. l	icense numbe	ЭГ		29d.	Date sign	ed (Monti	h, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	2		M	0. 1.	LA A A A A A A A	11.00	1)		(	O.C.M.E.			Aug	gust 9, 2	2012		
Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			30 Name and ac	dress of person	on who complet	ed cause of	death (Ite	m 23a)									
									N. Baltimo	ore Street,	Baltimo	ore, MD 21	223				
		100	04 D to 61-1-44						12.5								

Amend #20b per F AACO Health Dept	0 20 12 VAU		ndelible Ink. Ensure artment of Health and						
	1 - For State Registrar		tificate of Death	Reg. N	2012 27521				
Physician/	1. Decedent's Name (First, Middle, Last)	Peloquin		2. Date of Death AMount 6	3. Time of Death				
Medical Examiner	4a. Facility Name (if not institution, give street and num Washington Adventist Ho		4b. City, Town, or Location of Death  Takoma Park	1 4	4c. County of Death Montgomery				
Funeral Director	220-32-1602	7. Ag <u>e (In</u> yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Maryland				
yland f show ed at	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo			10d. Inside City Limits				
th the Maryland 3a or 28a-f sho t be notified at	Maryland   Prince George's  10e. Street and Number  12101 Ballina Court	Ft. Wash	11ngton 10f. Zip Code 20744	10g. (	Citizen of What Country?				
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ★★ Widowed 4 □ Divorced  1 □ Ves If Yes, Giv. Year or Dark	2 🔀 No	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business Industry  Dentistry  In Surname)  Artino  or Town, State, Zip Code)  yland 21112  Location - City or Town, State  rlington, Virginia  alas Funeral Home PA  1, Maryland 20745  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  Duse contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygtene. mportant: If item 27 is marked other than "natural", o myn injury or other traumatic event, the Medical Exam note.  To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-2 years	(Give	dent's Usual Occupation kind of work done during most of wor O NOT use retired) ntal Hygienist	king 16b.	,				
land 2 be filed w ental Hygi ked other ic event, t	17. Father's Name (First, Middle, Last) Oscar Lee Mo	•							
Mary 12 should alth and M 27 is man r traumat	19a. Informant's Name/Relationship (Type, Print)  Angela P. Moss / Daughte		ng Address (Street and Number or Ru Seneca Drive Od						
more, age 1 and ent of Hee nt: If item	20a. Method of Disposition  1 X Neurial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer	sition (Name of 9/6/20	<b>)∮2</b> e 20c.	Location - City or Town, State				
Balti permit. B Departm Importa any inju	21. Signature of Funeral Service Ligense	22		eorge P. Ka	alas Funeral Home PA				
Physician	23a. Part 1. Enter the disease, of complications that c shock, or heart failure. List only one cause on ear Immediate Cause (Final	aused the death. Do not ente		or respiratory arrest,	Approximate Interval Between				
Medical Examiner		or as a consequence of):	3400 000 00	J	La rec				
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	or as a consequence of):							
60 ate be executed hysician and the burial-transi	resulting in death) Last Due to (	or as a consequence of):							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trar Medical Certificate: To Be Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, out 1 ☐ Live I 4 ☐ Pregu								
IS, P.O  uires that the signed by lid be detailed by PP	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								
Record The law require has been lage 2 shou				24a. Was an autopsy performed?	prior to completion of cause of death?				
tal F	25. Was case referred to medical		26. Place of Death (Che		NO 72 TO 22 TO				
n of Vij ing Physic ing Physic in		Inpatient 2 ER/Outpatier of injury h, Day, Year)  ER/Outpatier 28b. Time of injury	28c. Injury at work?	lome 5 Residence 28d. Describe how inju					
ivision of or Attending Pafer death. Director: After the in by the funera	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place building	of Injury - At home, farm, str ng, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)				
Di To the Hospital within 24 hours a To the Funeral Ic completed filled	29a. Certifier 1. Certifying Physician: To the but 2. Medical Examiner: On the bas	is of examination and/or inves		at the time, date and place	ce, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier	To the best of my knowledge, to	29c. License number 68049	29d. D	Date signed (Month, Day, Year)  0 8 / 06/2012				
- 540°	30. Name and address of person who completed caus	e of death (Item 23a) (Type, F	Print)		2K NID 20912				
State Registrar			have						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ Edmund F. Phillips 2012 12:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Hospice House Talbot Easton 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Hours 1 🛛 M 2 🗆 F 188-14-5564 Pennsylvania **Director** 93 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Talbot Trappe 1 🗌 Yes 2 🏞 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21673 Chesapeake Care Givers Krismor Court United States be filed within femal Hygiene. "natural", or iten... arked other than "natural", or iten... vent, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 42-45 Year or Dates. Maryland 21215-0036 Spec White 1 Yes 2 No Specify 3 Widowed 4 Divorced Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Delmarva Power Co. Field Technician 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Frances Gillan and Mental F is marked of Harry Thomas Phillips 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Dulin/Daughter 30449 Gene Gibson Road, Easton, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 08/21/12 Hurlock, Maryland Easton Sh. Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD 21632 CFSP 216 N. Main St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ days Sepsis

Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ue to (or as a consequence of) Exami nding physician and ise as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last aspiration Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Day Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ b Hospital or Attending Physician: The law requires to 24 hours after death.
Funeral Director: After this certificate has been sign. Division of Vital Records, dementa 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No performed To the Funeral Director: After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Universing Home 5 Residence 6 Other (Specify) HOSPICE 1 Tes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗔 To the P within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57860

DHMH 17 Rev 7/2009

State Registrar (dlewild

Easten, MD 2169

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed Month, Day, Year

508

37. Registrar's Signature

12-06070 Troy Allen Pearson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 27538

		1- For State Registrar		Ce	ertificate	e of	Death				Reg. No			
Physicia ¶edical Exami	ın/	1. Decedent's Name (First, Midd Troy Allen								2. Date of De Month August 1	3, 201			3. Time of Death 1614 hrs
		4a. Facility Name (if not institution Memorial Hospital	on, give street and nu	imber)		41	b. City, Town, Easton	or Locati	on of Death			c. County o Talbot	f Death	
Funeral Director		5. Social Security Number 218-88-4528	6. Sex	7. Age (In yrs.	last birthda	ay) Yrs.	If Under 1 Y		ours Min.	8. Date of B	,		9. Birti Foreigi Cou	hplace (State or California untry)
id how any ce.		Usual Residence of Decedent 10a. State 10b. County Maryland Tal	hot	10c. City	y, Town or I									10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number  11548 Kittys	-		COLU	Ova	10f. Zip Code	1625			10g. Cit	tizen of Wh	at Coun	try?
after death will, or items	by Funeral	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div	arried 12. Was Dec Armed F. 1 Yes vorced If Yes, Give Yes or Dates:	cedent Ever in U orces? 2 1 No		If Ye	Decedent of s, specify Cul	Hispanic pan, Mexi No <i>spe</i> c	can, Puerto f	Rican, etc.)		14. Race White Specify:	, etc. Wh	an Indian, Black,
136 hin 72 hours ie. than "natur edical Exami	ompleted t	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12 H.S. Grad.			- dur	ing mo	s Usual Occu st of working I ician					Kind of Bus		e/Mechanics
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturinjury or other traumatic event, the Medical Exami	BeC	17. Father's Name (First, Middle Clarence O'Ne 19a. Informant's Name/Relations	ill Pears	on			Address (St	SI	nirley	First, Middle,	, Maider e Gre	surname) een		
'e, MD 2 1 and 2 shoul Health and IN fitem 27 is m	2	Renee L. Pears	on/spouse	20b.	11 Place of D	548	Kitty ion (Name of	s Co	rner R		Cord	ova, l	Mary	rland 21625 Town, State
Baltimore, I permit. Pages I and Department of Heal Important: If item		1 A Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	om State St. Lut		22. Na	ar place) rangelicz ch Cene ame and Addr	ess of Fac	cility Mo	0/12 ore Fu	nera	al Hor	ne,	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		h. Do not e	nter the	South mode of dyir					, Mary ock, or hea		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence	of):		ase				_			Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	Contequeños	of):									
760, icate be executed physician and the burial - transit		events resulting in death) Last UNPENDED	dAMENDED	consequence	от):									
ox 68760, eath certificate be attending physicia for use as the buria	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes,	outcome of pre- pirth pant at time of d	2	_	al death	3 Ect	opic pregnar	осу	23	d. Date of o	delivery Da	ay Year
P.O. BOX Is that the death congred by the attention detached for us	by Physi	1 Yes 2 No 9 Uni	uns contributing to					e given ir	Part I.		_		_	he cause of death?
of Vital Records, P ag Physician: The law requires t the this certificate has been sign neral director, page 2 should be d	Completed				-					24a. Was	s an opsy formed?	24b. W	ere aut	opsy findings available ompletion of cause of
Vital Rec ysician: The I his certificate I director, page	Be Co	25. Was case referred to medica examiner?	\$100 miles						ath (Check o		2	10	V 163	2 140
_ = . <	의	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pene	28a. Date (Month	of Injury Day,Year)	ER/Outpa 28b. Tim		ury 28c. II	Other njury at W Yes 2	ork?	Home 5 28d. Describe				
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Cou		e of Injury - At I	nome, farm,	street	, factory, offic	e building	, etc.	28f. Location or Town,		and Numbe	r or Rur	al Route Number, City
DIV To the Hospital or within 24 hours afte To the Funeral Dir	edical	one) 2 Medical Exa	hysician: To the bes miner:On the basis and manners	of examination			on, in my opini	on, death	occurred at		e and pla	ace, and du	e to the	cause(s)
	Σ	29b. Signature and title of certific	Hal	lai				nse numb	oer			gust 14,		th, Day, Year)
			Assistant Medic	al Examine	er 900 '	W. B	altimore S	reet, B	altimore,	MD 21223	3			
St Regist		31. Date filed (Month, Day, Year)	2012 32 Re	egistrar's Signa	ture									
DHMH 17 Rev 1/20	001				ORIG	INAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 2

			For State		State of	f Marylar		artment of l tificate of				-	012	27539
		_	Registrar  1. Decedent's Name	First Middle I a	et)		Cer	uncate or	Deam		2. Date of De		UIZ	1
	Physicia		Betty J.	1 112	31/						Month Aug.	Day 12	2012	3. Time of Death 2. 11:00 A M
	Medic Examin		4a. Facility Name (if		e street and numb	ber)		4b. City, Town, o	or Location	n of Death			nty of Death	
			Caroline		Home			Denton				Caro	oline	
	Funeral Director		5. Social Security Nu 217-24-90		Sex □ M 2 🔀 F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da 7/25)	1924	g. Birth Cou <b>Kan</b>	nplace (State or Foreign Intry) Sas
	od Jow at	ايا	Usual Residence of 10a. State	Decedent 10b. County		10c Ci	ty, Town or Loc	cation						10d. Inside City Limits
	arylar a-fst fied	Director	MD	Caroli	ne.		nton							1 XYes 2 □ No
	or 28 or 28 or oti	[출	10e. Street and Num					10f. Zip Code				10g. Citizen	of What Cou	
	with t	Funeral	520 Kerr	Ave.				21629				Unit	ed Sta	ates
	death items		11, Marital Status		12. Was Deced			Vas Decedent of F f Yes, specify Cub	lispanic C	rigin? (Spe	cify Yes or No-	14. F	lace - Amer	ican Indian,
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Marri 3 🙀 Widowed		1  Yes If Yes, Give Year or Dat	2X No		Yes 2 XNo			ilouii, otoi,	Spec	Black, White cify: Wh.	ite
5-0	"natu	plet	(Spe	15. Decedent's I			16a. Deced	lent's Usual Occu kind of work done	pation	est of worki	na	16b. Kind o		
121	thin 72 ane. than the Me	Completed	Elementary/Seco		College (1-	4 or 5+)	Ìife. D	O NOT use retired	)	ost or worm	19			
<b>d</b> 2	ed wi Hygie other ent, tl	Be (	17. Father's Name (F	First, Middle, Last)			I HO	memaker	18. Mot	ther's Name	(First, Middle	Maiden Surna		
ılan	d be fi dental rrked tic ev	욘	Wright (	Cheek					Me.	lissa	Baumga	ardner	,	
Maryland	should and N is ma auma		19a. Informant's Na				1	ng Address (Street					n, State, Zip	Code)
	ind 2 selfth m 27		Whitie Wi		ohew			Chapel R	d., 1	Easto	n, MD 2			
Baltimore,	Page 1 a nent of H ant: If ite ury or ot			osition Cremation 3  Other (Spec		State	cemetery, cren	sition (Name of natory or other pla <b>crematio</b> r			/2012	20c. Location	on - City or J idge,	
Balti	permit. Page Department or Important: If any injury or once.		21. Signature of Eur	neral Service Licer	<sup>5ee</sup> Γ. β.	-	22	. Name and Addre	ess of Faci	ility				
	_	Н	23a, Part 1. Enter to	he disease, or con	plications that ca	aused the dea		camptom E or the mode of dyi					ury,	Approximate
	Ph, sician/		shock, or hear Immediate Cause ( disease or conditio				1 2.	nent	-					Interval Between Onset and Death
	Medical Examiner		resulting in death)		a.	or as a consec								
16	LXammer	Į.	Sequentially list con	nditions,	b. —								_	
	ed	Examiner	if any, leading to im Cause (Disease or	tying linjury	Due to (c	or as a consec	quence ot):							
	execut in and iai-trai	Exa	that initiated events resulting in death) L	3	C. Due to (c	or as a consec	(uence of):							
90	ate be executed physician and the bunal-transit	edical		•	d									
68760	rtifica ling pl e as tl	/Me	IF FEMALE:		On If you out	ome of press	000							
Box (	ath ce attenc for us	cian	23b. Was decedent in the past 12 r 1 ☐ Yes 2 2				al death 3	Ectopic pregnan Other (specify)	су				Date of deli Month	very Day Year
	that the death certific ned by the attending is detached for use as	Physician/M	1 ☐ Yes 2 € 9 ☐ Unknown	J No	9 🗌 Unkno									
P.O.	+ C 4	by P	Part II. Other signif	icant conditions	contributing to de	ath but not re	sulting in the u	nderlying cause g	iven in Pa	rt I.				the cause of death?
rds,	require been si should b	eted									1 📙			obably 4 🗌 Unknown
eco	Physician: The law requires this certificate has been signal director, page 2 should bo	Completed									24a. Was auto perfe	psy ormed?	prior to c death?	opsy findings available ompletion of cause of
al R	an; Th tificat tor, pe	Be C	25. Was case referre	ed to medical				26. F	Place of De	eath (Check		2 No	1 L Yes	2 U No
Vita	nysicia iis cer direct	70 B	examiner?	Mo	Hospital:	npatient 2	BR/Outpatien	it 3 🗆 DOA Oth	ner: 4	Nursing Ho	me 5 🗆 Resi	dence 6 $\square$ C	other (Specia	fy)
n of	nding Pt th. : After the funeral		27. Manne f Death  1 latural 2 Accident	5 Pending Investigation		of injury n, Day, Year)	28b. Time of injury	28c. Inju wor M 1 🗆	ry at	2		how injury occ		
Division of Vital Records,	or Atter after des Director in by the	Certificate:	3 Suicide 4 Homicide	6 Could not determined	28e. Place	of Injury - At h g, etc. (Specif		eet, factory, office			28f. Location ( City or To	Street and Nui vn, State)	nber or Rura	al Route Number,
Ω	To the Hospital or Attending Physician; within 24 hours after death and the Funeral Director. After this certification pleted filled in by the funeral director, is completed filled in by the funeral director, is a second	Medical	29a. Certifier 1 (Check 2	Certifying Phy	ysician: To the be	est of my know	vledge, death o	occured at the time	e, date an	d place, and	d due to the ca	ause(s) and ma	inner as stat	ted. ause(s) and manner stated.
	ithin 2 or the I	Me		Certifying Nu					ne time, da	ate and plac			manner as s	stated.
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	'		30. Name and addre	ess of person who	completed cause	e of death (Iter	n 23a) (Type, P	Print)	62	. 2-	-sin	am.	316	:38
	Stat	te	31. Date filed (Monti	n, Day, Year)	324Re	gistrar's Signa	ature							
	Registra	ar	A	UC ID Z	12	ma 1	11 /	Man I						

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARD JOSEPH PAQUIN 8:00  $\mathbf{A}^{M}$ AUGUST 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S QUEEN ANNE'S COUNTY HOSPICE CENTER CENTREVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** Hours Min JULY 28, 1928 1 **X** M 2 □ F WASHINGTON, DC Director 578-34-2637 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland must be notified at Director MILTON 1 Yes 2 X No DELAWARE SUSSEX 10f, Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral USA 19968 110 RED CEDAR DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 0. 1 X Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 🕱 Widowed 4 🗆 Divorced WHITE Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRIC ELECTRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAY DOANE ပ ALPHONSE RODRIQUE PAQUIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 821 OLD LOVE POINT ROAD, STEVENSVILLE, MD 21666 JOANN MARIE McGRATH/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date DELAWARE VETERANS MEMORIAL CEMETERY Burial 2 ☐ Cremation 3 ☐ Removal from State 13, MILLSBORO, DELAWARE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_ician/ CANLER 426 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death tate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate | 1 Yes 2 No Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be 6 XHOSPICE CENTER Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this ( 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: After t Matural 5 Pending within 24 hours after death. To the Funeral Director: A Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFAR 2540 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	Al	MEND #25, PER ME G	Type or Pr 30, 8/24	int in Black II	ndelible In	k. Ensure	All Copie	es Are Le	gible.
		For State Registrar	State of M		artment of t rtificate of l		ivientai H	ygiene Reg. No 20	
Physicia	an/	1. Decedent's Name (First, Middle, Las	in a				2. Date of D	eath	3. Time of Death
Medi	cal	Rosalind  4a. Facility Name (if not institution, give	Marie	Roby	4h Cib. Town	. Leasting of Dea			2012 1440 M
Exami	ner	WMHS-RMC			4b. City, Town, o Cumbe			4c. Count Alle	gany
Funeral Director		5. Social Security Number 217-86-9041 1  Usual Residence of Decedent	PX 7. Ag	de (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		<sup>irth</sup> 1963	9. Birthplace (State or Foreign Country)
Maryland 28a-f shor	Funeral Director	MD 10b. County Allega	iny	10c. City, Town or Lo Cun	nberland				10d. Inside City Limits 1 🗡 Yes 2 □ No
with the is 23a or	neral D	10e. Street and Number 501 E. Oldtown F	Road		10f. Zip Code	21502			What Country? USA
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Armed Force 1  Yes 2  If Yes, Give Year or Dates.	No	Was Decedent of H f Yes, specify Cuba I Yes 2 No		Specify Yes or No rto Rican, etc.)	14. Rad Bla Specify	ce - American Indian, ck, White, etc. v: <b>white</b>
72 horn	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of wo	orking	16b. Kind of E	Business/Industry
212 within giene.		Elementary/Secondary (0-12)	College (1-4 or		Manager			Hospita	ality
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o	To Be	17. Father's Name (First, Middle, Last)  Robert M. McC				18. Mother's Na Regin	ame (First, Middle na M. Smit	e, Maiden Surnam N	ie)
re, Mai 1 and 2 short of Health and item 27 is nother traum		19a. Informant's Name/Relationship (Tive Roby	pe, Print) hus			Wn Road	ural Route Numb		S <sup>tate, Zip</sup> MD 21502
Baltimore, permit. Page 1 and Jepartment of Hea Mportant: If item any injury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo		irden <b>s</b>	Date 8/7/2012	20c. Location LaVa	- City or Town, State
Baltimory permit. Page 1 a Department of b Important: If ite any injury or ot		21. Senatur of Funeral Survice license		22	. Name а <b>8юакре</b> 108 Vi			land, MD 21	1502
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the Hospital or Attending Physician: The law requires that the death certificate be eithin 24 hours after death.  This 24 hours after death.  The certificate has been signed by the attending physician the left of the funeral Director: After this certificate has been signed by the attending physician the left of the funeral director, page 2 should be detached for use as the burner.	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XNo g ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death 3	Ectopic pregnanc	ey .			ate of delivery onth Day Year
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		30. Name and address of person who co				1716 HWA	Y CAVA	LE, MUT	17 CAND 21502
State		31. Date filed (Month, Day, Year)  AUG 28	32. Registra	ar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012

		•	State Registrar		Cer	tificate of L	Death	R	teg. No.		
	Physicia	ın/	Decedent's Name (First, Middle, Last)	71				2. Date of Deat Month		_Year_	3. Time of Death
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<b>)</b>	Examin	er	Southern Maryla		. 1		r Location of Death inton	٦	4c. County		eorge's
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year	If Under 24 Hrs.		1	9. Birthpl	ace (State or Foreign
	Director ≥		215-72-2788 Usual Residence of Decedent		Yrs.	Months Days	Hours Min.	(Month, Day, 2/4/1	958	Counti	
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	or iter	by Fu		Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America k, White, e	
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	s after de		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	<ol> <li>Place of Injury - At home building, etc. (Specify)</li> </ol>	e, farm, str	eet, factory, office		28f. Location (St City or Town		er or Rural i	Route Number,
Hospital of	in 24 hou he Funera pletely fill	Medical	(Check 2 \(\sum \) Medical Examiner.	: To the best of my knowled On the basis of examination a actitioner: To the best of my	ind/or inves	tigation, in my opini	on, death occurred	at the time, date ar	nd place, and due	e to the cau	se(s) and manner stated.
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dr			30. Name and address of person who compl	175035	2771	. 1	0.0	whai	1, Mc	20	735
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П	Dhypinia	-/	1. Decedent's Name (First, Middle	Last)						Date of Dea     Month	Day	Year		of Death
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mark!	Euparal		Brooke Grove No.  5. Social Security Number		7. Age (In yrs. la	st birthday)	If Under	Year	If Under 24 Hrs.	8. Date of Birt	h	g. Bir	thplace (State	or Foreign
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Baltimore, Maryland 21215-0036	of and 2 should be file of Health and Mental Fiftem 27 is marked or other traumatic ever	П	19a. Informant's Name/Relationsl			19b. Mailin 6394	ng Address Sunse	(Street and	d Number or Run .ght, Col	al Route Numbe Lumbia,	MD 2	wn, State, 2 L 0 4 5	ip Code)	
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	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph To the Funeral Director: After this certificate has been signed by the attending ph Completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the complet	Medical	(Check 2 D Medical	g Physician: To the Examiner: On the ba	asis of examination	n and/or inves	stigation, in	my opinion	n, death occurred	at the time, date	and place, a	and due to the	e cause(s) and	manner stated.
	of the vithin of the complete	Ž	only one) 3 LJ Certifyin 29b. Signature and title of certifie	g Nurse Practitione	er: To the best of	my knowleage	290	. License	number				nth, Day, Year)	
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	r		30. Name and address of person	who completed car	use of death (Item	n 23a) (Type,	Print)	p11	., Silve	or Court	Or MT	2000	6	
			Samuel Maller,				AOLIG	PTAG	., DIIV	=r shrri	rii egi			
	Sta Registi		31. Date filed (Month Day Year)	2012	Registrar's Sign	ure A	No.							

12-05821 Patrick Rafferty Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 27544

		1- For State Registrar	Ce	rtificate of	Death		R	eg. No.	
Physici		Decedent's Name (First, Middle,Las					2. Date of Dea Month		3. Time of Death
edical Exami	iner	Patrick Anthony					August 4,	2012	1139 hrs
		4a. Facility Name (if not institution, given 201 Hungerford Drive	e street and number)	1	4b. City, Town, o Rockville	or Location of Dea	th	4c. County of Death Montgomery	
Funeral		Social Security Number     6. Security Number	7. Age (In yrs. I	last birthday)	If Under 1 Ye			th (MM/DD/YYYY) 9. Bir Foreig	an.
Director			м 2 г 65	Yrs		ys Hours M	March !	17, 1947 Was	untry) hington, DC
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locati	ion				10d. Inside City Limits
	_	MD Mont	gomery	Gaither	rsburg				1 Yes 2 X No
larylar 8a-fs	Director	10e. Street and Number	80		10f. Zip Code		1	0g. Citizen of What Cou	ntry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fabow a matic event, the Medical Examiner must be notified at once.		18945 Quail Vall	ey Blvd.		2	20879		USA	
th with	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?			lispanic Origin? ( : an, Mexican, Puer		- 14. Race - Amer White, etc.	can Indian, Black,
ter dea			1 Yes 2 X No	1	Yes 2 X N	o specify:		Specify.Whit	e
ours af	d by	15. Decedent's Education (Specify or	or Dates:	16a. Deceden	t's Usual Occup	ation (Give kind o		16b. Kind of Business/	
6 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	ost of working lif	e. DO NOT use re	etired)		
15-003 filed within Hygiene d other that	E C		4	Life 1	Insuranc	ce Agent		Life Insu	rance
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natur e event, the Medical Exami	Be Co	17. Father's Name (First, Middle, Last)  John F. Rafferty					ne (First, Middle, M ny F. Me.	Maiden Surname) 11 <b>ing</b>	
2121; ould be fil d Mental F s marked itc event, 1	To E	19a. Informant's Name/Relationship (T	ype, Print )	19o. Mailing	Address (Stre	eet and Number or	Rural Route Num	nber, City or Town, State	, Zip Cooe)
e, MD 1 and 2 sho Health and item 27 is		Mary Rafferty Wie					-	ott City, M	
ages 1 and nt of Healt it. If item other trau		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	Place of Disposi crematory or oth	ner place)	·	Date	20c. Location - City or	Town, State
altimore, mit. Pages I an epartment of He iportant: If ite		4 Donation 5 Other Specify:		ropolit		atory	Aug. 10 2012	Alexandria	, VA
Baltimorr permit. Pages 1 Department of F Important: If injury or other		21. Signature of Funeral Service Licent	man en	[500	J Univer	rsity Bly	7d. W.,		gn, MD 20901
Physician /Medical		23a. Pan I. Enter the disease, or compl failure. List only one cause on ea		. Do not enter th	ne mode of dying	g, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner			Multiple Injuries Due to (or as a consequence o	£\.					Death
		Sequentially list conditions, b	sac to (or as a consequence o	17.					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence o	f):					
PSi A Se	xam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burtal - transit	/Medical Examiner	d. UNPENDED	AMENDED		1				
760 icate b physicate but the but	/Me	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of pregr	· —				23d. Date of delivery	
Box 68 death certifules attending	cian	past 12 months?	1 Live birth 4 Pregnant at time of de	oth	aldeath 3 ner (Specify)	Ectopic pregr	nancy	Month E	lay Year
Box 687 ne death certifing the attending	Physician	1 Yes 2 No 9 Unknown	9 Unkilown						
P.O.	2	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause	given in Part I.		bacco use contribute to	
cords, P.C.	Completed						24a. Was a	an 24b. Were au	topsy findings available
of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should t	ш						autop	med? death?	ompletion of cause of
	ပ္ပ	25. Was case referred to medical			26.Plac	e of Death (Check	1 Yes :	2 No 1 ✔ Ye	s 2 No
Vita ysicia his ce direct	ě	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence 6 🗸 Other	Scene
_ = . ` ;; [	ı.	27. Manner of Death	28a. Date of Injury (Month, Dax Year) Aug 4, 2012	28b. Time of In		ury at Work?	28d. Describe h Struck by tra	now injury occurred	
Division tal or Attendi rs after death.	catic	2 Accident Pending Investigation				Yes 2 ✓ No	20f Lagation (C	Need and Number of Du	al Davida Number City
Divi	Certification	3 ✓ Suicide 6 Could not be determined	oe		t, ractory, office	building, etc.		Street and Number or Rui tate) d Drive, Rockville, MI	
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	edical C	29a. Certifier 1 CertifyIng Physicia	an: To the best of my knowleds On the basis of examination a						
To with	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mor	ith, Day, Year)
5		4 M.	12		O.C	M.E.		August 5, 2012	
		30. Name and address of person who could be Jack Titus MD. Deputy (	ompleted cause of death (Item Chief Medical Examiner		Baltimore Str	eet, Baltimore	e, MD 21223		
	ate	31. Date filed Worth Day, Year) AUG 13 2012	3. Registrar's Signatu	part fork	4				
Regist	100	MAN TO COL	· Levelle 10.	17					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 Riffkin Andrew Ross 2012 1750 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Gaithersburg 11594 Game Preserve Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 213-78-3384 38 1 🗶 M 2 🗆 F Feb.18,1974 Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl Gaithersburg 1 Yes 2 No MD Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 28a ury or other traumatic event, the Medical Examiner must b 20878 11594 Game Preserve Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Completed by Black White etc. 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Physical Trainer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Riffkin Alan Marilyn Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Whelan Wife 11594 Game Preserve Road, Gaithersburg MD 20878 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Judean Memorial Garden's 8/15/2012 Olney, Maryland 22. Name and Address of Facility Cole Funeral Services, P.A. Sign 4110 Aspen Hill Rd.#100.Rockville.MD 20853 23a. Part 1. Enter the disease shock, or heart failure. Lis mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Phyllician disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician; The law requires that the death certificate be executed and trar that initiated events resulting in death) Last Due to (or as a consequence of) the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 as been signed by the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 L Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed' Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: Certificate: To 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🔀 Residence 6 🗀 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death. 28b. Time of 28c. Injury at 28d. Describe how injury oc¢urred 1 Natural 5 Pending self-inflicted asp wink 2 🗶 No AUP. 2012 Accident Investigation 6 Could not be 3 X Suicide 28e. ace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined zaraze mD 2087 within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

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Hankesbur

completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROGERS SHIKIALA AUGUST 9: 00AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL CITY BALTIMORE THE JOHNS HOPKINS None . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Y 220-39-2954 Director 18 1 □ M 2 🔀 F Oct. 1993 Maryland Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location the Maryland Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a None 1 X Yes 2 □ No Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 4230 Doris Avenue 21225 USA Page 1 and 2 should be filed within 72 hours after death v теnt of Health and Mental Hygiene. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or itel Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Black. Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, alth and Mental Hygiene. 127 is marked other than "rer traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) 10th Student Woodstock Job Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Terrell Rogers Shiray Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shiray Savoy (Mother) 4230 Doris Ave. Baltimore, Md. Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bestgate Mem. Park Annapolis, Md. 8/11/12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Wm 22 Reese & Sons Mortuary,
1922 Forest Dr. Annapolis, Larry Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and use as the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for L Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death signed by the a detached Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, been sig 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 death? director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

30. Name and

31. Date filed (Month,

DHMH 17 Rev 06-2011

address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

1800 ORLEANS ST BALTIMORE MD 21287

29d. Date signed (Month, Day, Year)

AUGUST 62012

	ou ai	State of Marylan	d / Depa <i>Cer</i>	artment of F tificate of L	Health and Death	Mental Hy	giene Reg. No.	0   2	275	; 47
Physician/	ent's Name (First, Middle, Last)  NIFERD N. R	ATASIEWICZ				2. Date of De Month AUGUST		2012	3. Time of 0	Death A M
Modiodi	y Name (if not institution, give stre			4b. City, Town, or	r Location of Dea			nty of Death	1.00	
	SMITH ROAD Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	ELKTON If Under 1 Year	If Under 24 Hrs		CEC		ace (State or	Foreign
Director 117-4 Usual Re	esidence of Decedent	M 2₹ F 49		Months Days	Hours Min		R 16,	Count		0
Director  Director  Dor State	10b. County  CECIL		y, Town or Loc KTON	cation				11	od. Inside City	
the Manual Toe. Street	et and Number			10f. Zip Code	,		10g. Citizen o		-	
Funeral Park with the Saa er must be er must be 11. Wasita	MITH ROAD  Status 12.	. Was Decedent Ever in U.S	S. 13, W	21921	ispanic Origin? (S	Specify Yes or No-	UNITED	ace - America		
, F'a   T'	lever Married 2 X Married	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No		to Rican, etc.)	Spec	lack, White, e	tc.	
within 72 hours after giene.  er than "natural", o, the Medical Exam  Completed by	15. Decedent's Educa (Specify only highest grade of		(Give k	ent's Usual Occupa		orking	16b. Kind of	Business/Ind	ustry	
within (giene. Gon Elemen	ntary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) SORTER			US POS	TAL SE	RVICE	
	's Name (First, Middle, Last)  L F • KALATA					ame (First, Middle, LA. BLAN		me)		
	mant's Name/Relationship (Type, LD W. RATASIEWI)		1	g Address (Street a				, State, Zip C	ode)	
	od of Disposition  Burial 2 $\stackrel{\frown}{M}$ Cremation 3 $\stackrel{\frown}{\Box}$ Rer  Donation 5 $\stackrel{\frown}{\Box}$ Other (Specify)	noval from State 20b. P	lace of Disposementery cremo FRDALE MATORY	sition (Name of eatory or other plac	e) AUG 20	UST 7,	20c. Location	n - City or Tov	vn, State	
Baltimo permit. Page Department of Important: If Important: Impo	ture of Fulfra Service	Merry	22.	Name and Addres	ss of Facility SP	ICER-MUI	LIKIN	FH	0	
shoo	Enter the disease, or complication, or heart failure. List only one complication.	tions that caused the death ause on each line.	n. Do not enter	r the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Betw	reen
Medical disease of resulting	te Cause (Final or condition in death)	Due to (or as a consequ	ency of):	UMR	ays	1950		-	Onset and De	atn
Examiner	ally list conditions, b.	Due to for six a consecu								
Sequentia if any lear cause. Er Cause (Dr. Cause, Ch. C	ally list conditions, ting to immuficit ther Underlying issease or injury ted events  c.	one ro (or sa a correscu	ner Acier (CT):							
Ganse (D)  Canse (D)  Canse (D)  Canse (D)  Canse (D)	in death) Last	Due to (or as a consequ	ence of):							
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death c death c death c lin the siciar	decedent pregnant 23c. p past 12 months? Yes 2 \( \subseteq \) No Unknown	If yes, outcome of pregnar  1 ☐ Live Birth 2 ☐ Feta  4 ☐ Pregnant at time of d  9 ☐ Unknown	Ideath 3 🗌	Ectopic pregnance Other (specify)	у			Date of deliver Month I	y Day Ye	ar
Day Part II. Oth	her significant conditions contrib	outing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.		obacco use co Yes 2 No			ath? nknown
The law requires take has been signated a should be a							osy ormed?	death?	pletion of cal	
S certificat director. The same and second a	ase referred to medical			26. Pla	ace of Death (Che	1 \(\superset \text{Yes}\)	Q [L] No	1 Yes 2	? L No	
Physic 1 27. Manue	Yes 2 No	1 Inpatient 2 I	ER/Outpatient		4 U Nursing I	Home 5 Resid				
ath. To Aler the funeration of the function of the functio	latural 5 Pending	(Month, Day, Year)	injury	28c, Injury work M 1 🗆	Yes 2 No	28d. Describe h	ow injury occu	irred		
tal or Attending Fast after death.  al Director: After ted in by the funer or 1 to	uicide 6   Could not be lomicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (S City or Tox		ber or Rural F	Route Numbe	r
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certificate: To Be Completely filled in by the funeral director, page 2.  Medical Certificate: To Be Completely filled in by the funeral director, page 2.	ck 2  Medical Examiner: one) 3  Certifying Nurse Pr	n: To the best of my knowle On the basis of examination ractitioner: To the best of m	and/or investig	gation, in my opinio	n, death occurred	at the time, date a	nd place, and c	lue to the caus	e(s) and manr	ner stated.
29b 3ig qa	ature and title of certifier	on, Mr		29c. License	number 697	9	29d. Date sign	sed (Month, Da	ay, Year)	
4 14.	and address of person who comp	253 6	415	int) LN,	Haus	e da	Ga	le 2	107	8
State 31. Date fil Registrar	AUG 1 0 2012	32. Degistrar's Signatu	J. Spa	ald						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUS7 WILLIAM ELMER ROBERTS 4a Facility Name (if not institution, give street and number, 4c. County of Death HARLES IVISTA EDI ENTER Social Security Numbe 8. Date of Birth (Month, Day, Year) FEB. 26, 1933 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Hours 218-30-4288 1 x M 2 - F 79 VIRGINIA 10b. County 10c. City, Town or Location 10d. Inside City Limits CHARLES WALDORF 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 U. 3218 SAINT PETER'S CHURCH ROAD S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Thever Married Married Black, White, etc. 1 Yes If Yes, Give 1 ☐ Yes 2 Ho Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MANAGER CHANEY ENTERPRISES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LESTER ELMER ROBERTS VIOLET DUKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29307 HORSE RANGE FARM CT., MECHANICSVILLE, MI DENNIS WINDSOR/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO. CREMATORY 8-24-2012 ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lostridium disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Ectopic pregnancy Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check examiner?

Physician/ Medical Examiner Examine

attending physician and for use as the burial-trar

signed by the at d be detached for

page 2 should

funeral director,

filled in by

completely

s after death. the

within 24 hours a

Physician/Medical

Completed by

Be

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Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

MD

Director

Funeral

þ

Completed

Be

Examiner

**Funeral** 

**Director** 

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ms 23a or 28a-f sho must be notified at

or items 23a

"natural"

or other traumatic event, the Medical Examiner

Maryland 21215-0036

Baltimore,

should be filed and Mental H

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permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

2 X No

5 Pending

Investigation 6 Could not be

determined

1 Yes

27. Manner of Death

1 Natural

Accident

Suicide

29b. Signature and title of certifier

4 Homicide

29a. Certifier

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

on!	y one)
ne	5 ☐ Residence 6 ☐ Other (Specify)
RA.	Describe how injuny occurred

Other: 1/XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Hom 28c. Injury at work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt)

LAPLATA, Md 20646 32. Registrar's

28a. Date of injury (Month, Day, Year)

6 M

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Registrar

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:13 P.M. Mildred Lee Scott 2012 Medical Facility Name (if not institution, **Examiner** 11/15 Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Min 257-10-0772 91 **Director** 1 🗆 M 2 🔀 F 01/18/1921 GA with the Maryland 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Charles MD Waldorf 1 XYes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a r items 23a iner must l 2714 Sprague Drive 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Housekeeping Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o 2 Joseph Lee permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Mozella Thorpe 19a. Informant's Name/Relationship (Type, Print) Great 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Coley-Burrell/neice 2714 Sprague Dr. Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cother (Specify) Greenwood Cemetery 8/18/2012 Brunswick, GA Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home Kimbo Ly Chriscovou 2294 Old Washington RD Waldorf, 20601 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Os Sequentially list conditions, Due to for as a conseq. ce of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ in the past 12 months? Month Day Year Yes 2 No detached the 9 Unknown 9 Unknown contributing to death but not a sulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No remorina 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 npatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury death. 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A

of Vital

Baltimore, Maryland 21215-0036

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State

Registrar

(Check 29b. Signature and tit

death (Item 23a) (Type, Print) on Road Sut 2030 Walfor J. MD

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 10° 2012° 2 11:10 A M Evelyn Spector Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 577-16-9087 93 1 □ M 2 🔏 F New York Mar. 26, 1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-f sho eny Injury or other treumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 🕅 No Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 2900 N. Leisure World Blvd., #506 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) condary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moshe Gach Kate Cash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Spector, Daughter 10201 Grosvenor Pl., #1509, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ebanon Cemetery 08/12/12 Adelphi, MD 21. Summure of Funeral Service Licenses TorchiniskyssHebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Priysician/ Renal Cell Cancer disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlangesit Hospital or Attending Physlclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 XNo Pregnant at time of death Month 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No ျှ Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) August 10, 2012 D 37142 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 Coleman, M.D. 31. Date filed (Month, Day, Year) State AUG 13 2012 Registrar

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Theodore 1540 M 2012 Medical lugust 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death . SOLISBUIG REGIONAL Center HIODMICO PENINSULA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 219-44-1989 Director 1 **X**M 2 □ F pr:1.10. Maryland Usual Residence of Decedent 27 is merked other then "neturel", or Items 23e or 28e-f show treumetic event, the Modical Examiner must be notified at 10c. City, Town or Location Director Philadelphia 1 Yes 2 □ No Delaware 10e. Street and Number 10g. Citizen of What Country? Funeral 6146 Morton 19144 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Divorced Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 end 2 should be flied within 72 f Health end Mental Hyglene. Item 27 is merked other then " Elementary/Secondary (0-12) College (1-4 or 5+) 12 th grade 17. Father's Name (First, Middle, Last) elf employed Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Spencer Amanda Tul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ph. ladolphia Scott - Niece Deloves Morton St other 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pege 1
Department of
Importent: If it
eny injury or o ₽ 1 Burial 2 Cremation 3 Removal from State 113/12 Snow Hill 4 Donation 5 Other (Specify) Anthony E. 21. Signature of Funeral Service Licenses 22. Name and Address of Pacility 30639 Hampden Ave. Princess Anne, MD, 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ASCVD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physicien: The lew requires that the death certificate be executed ettending physician end I for use es the buriel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month erel Director: After this certificate has been signed by the e filled in by the funeral director, page 2 should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The lew within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s performed? Yes 2 K No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN SHAE DR. SAUSBUFY, MD, 2187. VOHRA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2012 Registrar

Box 68760

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27554 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day 201<sup>Year</sup> A M Pauline Harrington Smith 6, August 7:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 207 Maple Ave. Apt. 3A Greensboro Caroline 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days May 23, 1931 Months 1 □ M 2 😿 F 214-28-1248 Yrs. MD **Director** 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Caroline Greensboro 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code items 23a Funeral USA 207 Maple Ave. Apt 21639 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Aide Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl S. Harrington Mildred Baynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Smith/Daughter Ridgeway Circle Felton, DE 19943 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Aug.9, 2012 Greensboro, MD 22. Name and Address of Facility Greensboro, MD 21639 21. Signature of Emeral Service Licenses Fleegle and Helfenbein Funeral Home P.O. Box 160 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Vul mounty Disease Physician/ disease or condition resulting in death) YCAY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for de a corresquence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🔲 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforn death? Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 X No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 20053815

DHMH 17 Rev 7/2009

State

Registrar

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Date filed (Month, Day,

AUG 20

9/20 Market St Denton MD

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

UL/MOOD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27555 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15,2012  $A^{M}$ Sarah S. S. Spencer August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>Stella Maris</u> <u>Baltimore</u> <u>Timonium</u> 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours Director 212-20-5569 1 □ M 2 🙀 F 97 Yrs. Maryland 02/21/1915 parmit. Pega 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Baltimore MD Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 8800 Walther Boulevard .S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo 1 Yes 2 No Specify: If Yes, Give Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Richard Dallas Sheridan Lillian B. Silver (daughter<sup>19</sup>). Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Spencer-Davis 246 Rachel Circle, Forest Hill, MD 21050 <u>Susan H.</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 08/20/2012 Havre de Grace, MD Rock Run Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. Washington St., Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): ate has baen signed by tha attanding physician and page 2 should ba detached for usa es tha burial-transit Cause (Disease or injury or Attending Physician: The law raquires that the death certificata be exacuted Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No Division of Vital To the Funeral Director: After this certific complately filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 D Other (Specify) HOSPICE 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 XX Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and a dr

JACKIE JONES,

2012

AUGUST 15,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

erson who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST DARNELL **MARCUS** SKINNER 16<sup>y</sup> 2012 8:32  $p^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Union Hospital Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Month, Day Min. Hours 217-13-5181 <sup>°</sup>1987 Director 25 1**X** M 2 □ F Feb. Maryland Usual Residence of Decedent shov 10a, State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director New Castle New Castle 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 255 Parma Ave. 19720 U.S.A. ortant: If Item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 X Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo Specify: Yes Give Black 3 Widowed 4 Divorced Specify: Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ul Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Deli Helper Retail Grocery Store 12 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Johnson, Jr. Marion Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Margaret Skinner (sister) 255 Parma Ave. New Castle, DE. 19720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If Ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Union Bethel Cemetery 8/21/12 Cecilton, MD. 4 ☐ Donation 5 ☐ Other (Specify) Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate shock, or he Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical requires that the death certificate be P.O. Box 68760 SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the a 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law certificate has perform 1 Yes 2 🗌 No Yes 2 To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie on who completed cause of death (Item 23a) (Type, Print) un (item 23a) (Type, Print)
106 Bow Street Elkton

Registrar

DHMH 17 Rev 06-2011

AUG 2 8 2012

			State of Maryland / I	Department of He	ealth and Me	ental Hyg	iene 201	2 27557
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of De	T-	P. Date of Deat	eg. No.	3. Time of Death
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-4	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Lo	ocation of Death		4c. County of Dea	th
*	,		8500 Mike Shapiro Drive Apt 102	Clint			Prince G	
п	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 77		Hours Min.	. Date of Birth (Month, Day,	Year) Co	rthplace (State or Foreign ountry)
			Usual Residence of Decedent			Dec 23,	1934   Sou	th Carolina
	ryland I-f sho ied al	Funeral Director	10a. State 10b. County 10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 💢 No
	he Ma or 28a notif	Dire	Maryland Prince George's	CLinton  10f. Zip Code		1	0g. Citizen of What C	-
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	death items ner m		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Specif Mexican, Puerto Ric	y Yes or No-	14. Race - Ame Black, Whit	
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 1 Yes 2 ☐ No 1958	1 ☐ Yes 2 🔀 No		, ,		lack
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lary	should and M is ma			. Mailing Address (Street and				ip Code)
ري ∠	and 2 stealth		Clifton Thomspon (Son)	2013 New Hamps	shire Ave Ap			
Baltimore, Maryland	Page 1 and 2 should be file ment of Health and Mental Hant. If item 27 is marked of Lry or other traumatic even			f Disposition (Name of ry, crematory or other place)	Dat		20c. Location - City or	·
altin	permit. Page Department of Important: If any injury or once.	1	4 Donation 5 Other (Specify)  1 Ce  21. Signature of Funeral Survice Light/see	Crematory 22. Name and Address	Aug 12	, 2012	Clinton,	
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п			25a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying,	such as cardiac or re	espiratory arres	st,	Approximate Interval Between
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	_ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0():				
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9 ×	th cert ttendir or use	ian/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death				23d. Date of de	
. Box	ne dea / the a ched f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 U Other (specify)			WOTH	Day Year
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ds,	quires en sig ould b	ted				1 🔀 Ye	s 2 No 3 F	Probably 4 Unknown
Division of Vital Records,	has be	Completed				24a. Was an autopsy perform	y prior to	topsy findings available completion of cause of
Ä	n: The ificate or, pag	e Co	25. Was case referred to medical	26 Place	e of Death (Check or	1 🗌 Yes 2		s 2 No
Vita	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 ▼No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	0.11			nce 6 🗆 Other (Spec	cify)
l of	ing Ph kfter th uneral			ime of 28c. Injury at 28c. work?	t 280		w injury occurred	
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_	Hospit 4 hour Funera tely fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/o	death occurred at the time, der investigation, in my opinion,	date and place, and death occurred at the	due to the cause time, date and	se(s) and manner as s	tated. cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Me	only one) 3 Certifying Nurse Practitioner: To the best of my known 29b. Signature and title of certifier	vledge, death occurred at the 29c. License nu	time, date and place, umber	and due to the		as stated.
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	Funeral		Social Security Number     6.	Sex 7. A	ige (In yrs. las	t birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birth	place (State or Foreign
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	ath wil	Funeral	5185 Port Toba	cco Road  12. Was Decedent	t Ever in LLS	13 \	206		epanie Ori	ain? (Spe	cify Yes or No-	United	Stat	
9	er dez or ite miner	by F	1 Never Married 2 Married	Armed Forces	? No	l'	f Yes, spec	ify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		ck, White,	
003	ırs aft ural", IExa	ted I	3 Widowed 4 Divorced	If Yes, Give 1 Year or Dates.	$.938_{\overline{1}95}$	7	Yes :	X No	Specify:	;		Specify	∕: Wh	ite
15-(	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest				kind of wor.	k done d	ation u <i>ring</i> mos	t of worki	ng	16b. Kind of E	Business/In	dustry
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	and 2 Health iem 27 ther tr		Margie H. Taylo  20a. Method of Disposition	r/Wife	20h Pla	5185 ce of Dispo			icco		Nanjem	oy, Mar	•	
nor	age 1 ent of nt: If ii		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te cen	netery, cren	natory or o	her place			1-2012	Waldor	•	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		21. Signature of Funeral Service Lice		111									Home, PA
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Division of Vital Records,	ial or Attendest's after deat	l Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Ir	njury - At hom etc. <i>(Specify)</i>	e, farm, stre	eet, factory	office			28f. Location (S City or Tov	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 Medical Exa only one) 3 Certifying N	nysician: To the best of miner: On the basis of urse Practitioner: To t	examination a	and/or invest	igation, in n death occu	ny opinio irred at th	n, death oo ne time, da	ccurred at	the time, date a	and place, and duthe cause(s) and	ie to the cai	use(s) and manner stated stated.
	<b>6</b> ≥ ≥ ≤		29b. Signature and title of certifier	Meli	lu N	11)		License		46		29d. Date signe	of a	Day, Year)
	pa-10		30. Name and address of person who	completed cause of	death (Item 2	3a) (Type, P	rint)	1-11	N	41)	<u>/</u>	10 Pol	nt /	w)
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Registrar

AUG 10 2012 July D. park

12-05933 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stephen Michael Tripp 2012 27559 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Stephen Michael Tripp 1120 hrs **Medical Examiner** August 8, 2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Calvert 843 Pat Lane Huntingtown 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** oreign Country) MA Months Days Hours Director 59 02/21/1953 1 X M 2 F 014-38-3584 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No 28a-f show Calvert Huntingtown Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 843 Pat Lane 20639 United States Funeral 11 Marital Status 14 Race - American Indian, 8lack, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Armed Forces' 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: White 4 Divorced Specify: ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than traumatic event, the Medical 12 Signalman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Tripp, Sr. Gertrude Vanasse 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Tripp / Wife 843 Pat Lane, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) tant: If it 8urial 2 X Cremation 3 Removal from State 08/15/2012 Lee Crematory Clinton, MD 4 Donation 5 Other Specify. 22 Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee J. Goff 8200 Jennifer Lane, Owings, MD 20736 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line 8etween Onset and /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed' ✓ Yes 2 No 2 No certificate 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Subject shot self Certification FOUND: Natural 1 Yes 2 V No Pending hours after death. the f Aug 8, 2012 1120 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 843 Pat Lane, Huntingtown, MD within 24 hours a

To the Funeral I determined (Specify) Single Family Home Homicide completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ţ and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 29c. License number O.C.M.E August 9, 2012 Val 30. Name and address of person who completed cause of death (Item 23a) JRW) 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

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			State of Maryland / Dep	artment of Health and Me	ental Hygien	e 2012	27560
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. ! 2. Date of Death	No. L O I L	3. Time of Death
	Physicia Medic		Mulumbet Taffese	A	Month [	Day Year	7:35 PM
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4	-		Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Silver Spring  If Under 1 Year   If Under 24 Hrs.   8	B, Date of Birth	Montgome	
	Funeral Director		0.38 1	Months Days Hours Min.	(Month, Day, Year	r) Cour	
			Usual Residence of Decedent	<del></del>	une 5, 19		IIOPIA
, de	rryland I-f sho ied at	ctor	10a. State MD 10b. County 10c. City, Town or Lo	cation r Spring			10d. Inside City Limits  1 ☐ Yes 2 🌁 No
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+ Hive	s 23a ust be	Funeral Director	10014 Woodland Drive	20902		USA	ŕ
4+00	items items ner m		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Americ	
36	aller al", or xamil	d by		1 ☐ Yes 2 H No Specify:		Black, White, Black	C
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/lanc	d be life Mental H arked o	To	Taffese Ayele	18. Mother's Name (F Worke Yan		en Sumame)	
Baltimore, Maryland 21215-0036	permit, rage I and 2 should be there which 72 hours after death with the waryfaird permit. Fage I and 2 should be the Marial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ng Address (Street and Number or Rural R L4 Woodland Drive,			
ore,	of Hez fitem rothe		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Dat	te 20c.	Location - City or To	
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Balt	Depart Impor any in		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Cancis J. Collins F 00 University Blvd.	uneral Ho	ome Inc. ver Spring	g, MD 20901
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	h, sician/ Medical			cellular Carcinoma			Onset and Death
	Examiner		Due to (or as a consequence of):				
	<u> </u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
scuted	hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				
<b>50</b> te be executed	sician	dical E	resulting in death) Last				
760 Teate b	g phys	fedi	d				
Box 687	attending phy	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of deliv	ery
). <b>Bo</b> )	signed by the att	Physician/Med		Other (specify)		Month	Day Year
P.O.	gned b	by P	Part II. Other significant conditions contributing to death but not resulting in the Hypertension	underlying cause given in Part I.		o use contribute to the	
rds,	been signal	ted	nypercension		1 L Yes		bably 4 APUnknown
Division of Vital Records, talor Attending Physician: The law requires	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Completed			24a. Was an autopsy performed?	prior to co death?	psy findings available impletion of cause of
	ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check or			
f <b>Vi</b>	this c	욘	1 ☐ Yes 2 🛣 No			6 Other (Specif)	)
o u	th. After thi	cate	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	28c. Injury at work?  M	d. Describe how inj	ury occurred	
Visio	within 24 hours after death  To the Funeral Director.  Completely filled in by the	Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28	f. Location (Street a City or Town, Sta	and Number or Rura ate)	l Route Number,
	eral D		29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	due to the cause(s)	and manner as stat	ed
he Hos	in 24 h ne Fun pletely	Medical	(Check only one)	tigation, in my opinion, death occurred at the	e time, date and pla	ice, and due to the ca	use(s) and manner stated.
10	with Total		29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	Day, Year)
	T		for mis	D41624	A	ugust 8,	2012
				len Road, Silver S <sub>I</sub>	pring, MD	20910	
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 13 2012  32. Registrar's Signature	Stade			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Day O 9 Physician/ Donald K. Towson 05:13 AM 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Univ. of MD Medical center Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days 220-18-4697 Director 1 🛛 M 2 🗆 F 86 June 21, 1926 Maryland Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Perryville Cecil. 1X Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 21903 U.S.A. 612 Richmond Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 X Yes 2 No
If Yes, Give
Year or Dates 1944-47 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Army Aberdeen Proving Ground Aberdeen, Maryland Elementary/Secondary (0-12)
Eleven Years College (1-4 or 5+) Tool and Supply Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Irene Poteet ပ Harold Kirk Towson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 612 Richmond St., P.O. Box 166, Perryville, MD Bernedette Towson (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mark's Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Perryville, Maryland 08/15/12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Myocardial ischemia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 5 hrs Tumor lysis syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ₫**V**D Exami Cause (Disease or injury and that initiated events resulting in death) Last use as the burial-trai To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by congestive heart-fallure 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of Arrial fibrillation 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

LVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check

29c. License number 1215202312

29d. Date signed (Month, Day, Year) 08/09/12

225. Greene St Baltimore, MD 2120) NIKita Deshpande

State Registrar

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

		For State Registrar		•	Certificate of		Reg.	0010	27562
Physic	cian	<ol> <li>Decedent's Name (First, Middle, I Helen Mae Tuck</li> </ol>					2. Date of Death Month	Day Year	3. Time of Death 0652 M
/Med Exam		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, c	or Location of Death	MOUST	20 2012 4c. County of Death Carroll	
Funera Directo				e (In yrs. last birth			B. Date of Birth (Month, Day, Ye 01/14/1	9. Birth	place (State or Foreign intry)
and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location				10d. Inside City Limits
Maryla frsho	jo	MD Carrol	1	Westmi					1 ☐ Yes 2 🛣 No
h the or 28a	irec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
ath will	ral	225 Frock Drive,			2115			USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination to the Lydined at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Spec ean, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: W	
15-0	etec	15. Decedent's (Specify only highest t	Education trade completed)	16a. [	Decedent's Usual Occu Give kind of work done	pation during most of working ed)	168	b. Kind of Business/Ir	idustry
within than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	·+)	lite. DO NOT use retire Lerical	ed)		State of 1	<b>√</b> D
nd 2	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Name (			
ylar ylar ould be Menta arked attic ev	70 E	Samuel Franklin	Baker			Sophie A			
y, Maryland and 2 should be file ealth and Mental Hy n 27 is marked oth her traumatic event		19a. Informant's Name/Relationship Sophie Loss/sist		22	25 Frock Dr	ive, Apt.	153, Wes	tminster,	MD 21157
Baltimore, bermit. Pages 1 ar Department of Hea Important: If item 3 any Injury or other		20a. Method of Disposition  1 Burial 2 □ Cremation 3	☐ Removal from State		Disposition (Name of crematory or other pla			c. Location - City or T	,
Itin nit. Pa artmer artmer ortant: Injury		4 □ Donation 5 □ Other (Spe 21. S@nature of Funeral Service Lice		Meadowi	ridge Mem.	Park 08/23	/2012 El	kridge, M	) apol P A
B Per B		John K A	CI Sec	-		ngton Road			21157
Physiciar		23a. Part . Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final	ly one cause on each lir	ne.		ing, such as cardiac or	respiratory arrest	1	Approximate Interval Between Onset and Death
/Medica		disease or condition resulting in death)	Due to (or as	a consequence of	):	PISERSE			
Examine		Sequentially list conditions,	b. HYP	ERTEN a consequence of	SION				
uted J ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury			MELLIT	7./.5			
68760, tificate be executed g physician and as the burial-transit	Exa	that initiated events resulting in death) Last		a consequence of					
68760, ificate be ex g physician is the burial	edical		d OBE	SITY					
		IF FEMALE:	23c. If yes, outcome	of pregnancy				Ond Date of deliver	
I Records, P.O. Box The law requires that the death cert the has been signed by the attendin. page 2 should be detached for use to	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of deliver Month	very Day Year
cords, P.O. w requires that the d been signed by the should be detached	y P	Part II. Other significant conditions		_		*	23e. Did tobac	cco use contribute to	the cause of death?
Records, he law requires the has been signe	ted	COPO, BIPOLAR, G	erd, DEPRES	SSION, H	YPOTHYROI	D	1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
Aec e law r has be ge 2 sh	nple	SLEEP APNEA,	HYPERCH	OLESTER	OLEMIA, BR	CONCHIAL	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Vital Ristairs Sicien: The certificate herector, page						ASTHINA	performe 1 🗆 Yes 2 💆	d? death? 1 ☐ Yes	2 <b>5</b> 0
Vital slcian: T	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No	Hospital:	ent 2. K. ER/Outs	octiont 3 DOA Oth	26. Place of Death (		e 6 □Other (Spec	7.E. A
n of ig Phy ter this		27. Manner of Death	28a. Date of Inju	ry 28b. Ti		iry at 28	d. Describe how		119)
Sior rendin eath. or: Af	catio	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	on	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2 □ No			
Division of tall or Attending Phy rs after death. al Director: After this led in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determine		ury - At home, farn c. <i>(Specify)</i>	n, street, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
Division of Vita  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical		Physician: To the best aminer: On the basis o and manner sta	f examination and					
To with	2	29b. Signature and title of certifier	200		29c. Licens	se number	29d	Date signed (Month)	Day, Year)
7 m	1	30. Name and address of person w	o completed cause of d	eath (Item 23a) (T	ype, Print)	2/11	,	5/21/12	-
V.		Kevin Smot	hers, mi	2001	Nemoria	( Ave, u	estmo	inster, a	10 21157
	tate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	Kent.			7	
Regis	trar	HUG NO LOIL	Manual .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

12-05987 Kevin Stanley Williams Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 27563

		1- For State Registrar	Ce	rtificate of D	eath		,,,	Reg. No		112	2130
Physici edical Exam							2. Date of Month Augu	of Death Day st 10, 20	Year		3. Time of Death 0441 hrs
		4a. Facility Name (if not institution, g Highway 26 Liberty Road			City, Town, o	or Location of D		4	c. County o		
Funeral Director		441-04-4909	Sex 7. Age (In yrs. X M 2 F 21		Under 1 Ye		Min.	_		Foreign	place (State or
w any		Usual Residence of Decedent  10a. State  10b. County	3,,, 2,,,	, Town or Location			Fer	o.7, 1	991		0d. Inside City Limits
Maryland 28=f show datonce	ţō	Maryland Freder	rick	Frederick							1 X Yes 2 No
with the Maryland ms 23a nr 28a-f sho be notified at once.	Il Director	10e. Street and Number 2021 Buell Drive			f. Zip Code	21702		,	nited	Sta	tes
MD 21215-0036  Should be filed within 72 hours after death with the Maryland b and Mental Hygiene.  27 is marked nither than "natural", nr items 23s nr 28s-f sho matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Marrie	1 Yes 2 X No	If Yes, s	pecify Cuba	lispanic Origin? an, Mexican, Pu			White,	etc.	an Indian, Black,
urs afte tural", amine	d by	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade completed)	16a. Decedent's U		ation (Give kind		16b.	Specify: T Kind of Bus		
21215-0036 ould be filed within 72 ho I Mental Hygiene. I marked nther than "na ic event, the Medical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			e.DONOTuse erapist			Healt	h Ca	re
5-0036 iled within 77 Hygiene. Inther than		17. Father's Name (First, Middle, Las	st)	Thysica	<u> </u>	18.Mother's N				ii oa	10
2121 ould be fil marked ic event,	To Be	Kenneth Williams 19a. Informant's Name/Relationship		19b. Mailing Add	dress (Stre		Ann Sh			State 7	7in Code\
MD 2 d 2 shou lth and I a 27 is numatic	F	Sarah A. William		2021 Bu	,				•		'
Fe lan fitter fr		20a. Method of Disposition  1 Burial 2 Cremation 3	20b.	Place of Disposition crematory or other p	(Name of ce		Date		Location - (		
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		4 Donation 5 X Other Specif 21. Signal of Fune Service Lice	y: Entombment Mt			ery 8	/16/20:	l2 Fr	ederi	ck,M	laryland.
	Ç	Jode SIA	MXII	Stau: 1621	ffer H	Funeral sumtown	Homes Pike,	P. A. Frede	rick,	Mary	land 21702
Physician // /Medical		23a. Part I. Enter the disease, or com failure. List only one cause on e	each line.	i. Do not enter the mo	ode of dying	g, such as cardi	ac or respirato	ry arrest, sr	ock, or hear	1	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries  Due to (or as a consequence of	of):						-	
	Jer	Sequentially list conditions, if any, leading to immediate									
ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):							
1760, ficate be executed g physician and the burial - transit	Medical	UNPENDED	AMENDED	<u> </u>						$\dashv$	
68760, certificate be nding physici se as the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		0			23	d. Date of d	,	M
Aecords, P.O. Box 687 The law requires that the death certific cate has been signed by the attending ipage 2 should be detached for use as it.	Physician	past 12 months?  1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant at time of de	2 Fetal de	eath 3 (Specify)	Ectopic pre	egnancy	_	Month	Day	y Year
O. E nat the or detached		Part II. Other significant conditions	contributing to death but not r	esulting in the under	lying cause	given in Part I.					e cause of death?
S, P, quires the signer of signer of the sig	ed by										oly 4 Unknown
23e. Did tobacc  1							autopsy perform <u>ed</u> ?				
in i	Be Co	25. Was case referred to medical			26.Plac	e of Death (Che		res Zr	10	<b>y</b> Yes	2 No
Physici r this c	일	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA		rsing Home	transact .	ence 6 🗸		cene
C# . 4	ation:	27. Manner of Death  1 Natural 5 Pending  2 ✓ Accident Investiga	28a. Date of Injury (Month, Day, Year) Aug 10, 2012	28b. Time of Injury 0437 hrs		ury at Work? Yes 2 ✔ No		pedestria			
Division pital or Attendi ours after death. eral Director: A	Certification:	3 Suicide 6 Could no determine			ctory, office I	building, etc.	or To	tion (Street a wn, State) 26 Liberty			Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
F 5 F 5	ž	29b. Signature and title of certifier				29c. License number			29d. Date signed (Month, Day, Year)		
		30 Name and address of parson who	O.C.M.E.  O. Name and address of person who completed cause of death (Item 23a)					August 10, 2012			
3			ssistant Medical Examir		altimore S	Street, Baltir	more, MD 2	21223			
St Regist		31. Date filed (Month, Day Year)	2012 32. Registrar's Signatu	p. par	الما						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JAMES** WESLEY 7:00 PM WHEELER August 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5221 Frances Drive Crisfield Somerset Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year, 1 XM 2 □ F 1925 Mary land 86 **Director** 220-22-2976 Auq. "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Somerset Crisfield 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5221 Frances Drive 21817 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No World Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates.War II the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) <u>Postal Worker</u> US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Benjamin Wheeler Christina Luh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kay A. Wheeler (Wife) 5221 Frances Drive - Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 08/13/2012 | Delmar, DE 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Signstya of Funer 3 e State St 306 W. Main St. - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ ASCU D disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of). or Attending Physician; The law requires that the death certificate be executed and -trans physician ar s the burial-to resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year the a g Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗆 No Yes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Mannyer of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Matural 5 Pending work 124 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 1+50497 112

Registrar
DHMH 17 Rev 7/2009

State

hris

31. Date filed (Month, Day

Salisbu

21801

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D.O.

Snyder

AUG 1

100 E. Carroll St

amend #5 Per FH G932 10/2012 JH State of Maryland 7 Department of Health and Mental Hygiene For State Registrar 27565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $20\overset{\text{Yea}}{12}$ Physician/ 1745 Harry Joseph Welsh August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth Sept. 21,1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Min Pennsylvania Days Hours 88 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showny injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location Director Perryville 1 🏋 Yes 2 ☐ No Cecil Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21903 618 Arch Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give 104 Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: Year or Dates 1942-46 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor C&P Telephone Company Twelve Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Huth Harry Joseph Welsh, Sr. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Arch St., P.O. Box 1, Perryville, Maryland 21903 Madeline P. Welsh (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/11/12 Port Deposit, Maryland Asbury Cemetery 21. Signature of Funeral Service Ligensee Leemaand Frankerson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Ceath Immediate Cause (Final FAILURE Physician/ ACUTE RENXI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEART ONGESTINE Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying PNEUMONIA attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, 6.0. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death SELSE, TARRY 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes Yes 2 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number 8-8-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1VA Revolution Street, House de Grace MD 21078 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM August 2017 Henrietta Mary Weller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Director 219-20-1296 1 □ M 2 🛛 F 86 Yrs. MD 09/03/1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No Washington Hancock 10e. Street and Numbe 10f, Zip Code 23a or 10g. Citizen of What Country? must be Funeral USA 8903 Corner Road 21750 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. "natural", or ite Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other the raumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hazel Irene Sharer Earl Franklin Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 1414 Orchard Ridge Road Hancock, MD 21750 Larry L.Weller/Son Department of Healt Important; If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ∏ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Orchard Ridge Cemetery08/17/2012 Hancock, MD Signature of Funeral Service Licens 22. Name and Address of Facility Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, shock, or heart failure. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying 1 your dire Infant Cause (Disease or injury burial-trar that initiated events resulting in death) Last physician Physician/Medical as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of has performed? Yes 2 N death? 1 🗌 Yes 2 XNo 25. Was case referred to medical examiner?

1 Yes 2 No To Be 26. Place of Death (Check only one) Other: 1 Mnpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Division of Vital To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Registrar

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

astram?

OPAI

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CT. HAGERSTOWN MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month **Physician** Ella Mae Wirtz 20 Aua. 7:30 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16705 Dubbs Road Baltimore Sparks If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛱 F 219-42-0389 69 Nov1, Director 1942 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinatment to an ithical at Director 1 ☐ Yes 2 🛛 No MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16705 Dubbs Road 21152 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, Ite Medical Exemina 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specity: \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph G. Haga Ruth S. Chandler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward A. Wirtz Jr/Husband 16705 Dubbs Rd. Sparks, MD 21152 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Dulaney Valley Memorial Gardens Aug. 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 2012 22. Name and Address of Facility JJ Hartenstein Mortuary, ture of Funeral Service Lice Inc. N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) à luteral Acleroses /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (of as a consequence of requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.O. signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy The performe Division of Vital 1 ☐Yes 2 No 2 No ospital or Attending Physician: hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending neral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of ce South Main St-Hampstead o completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar face

27568 State of Maryland / Department of Health and Mental Hygier [ ] Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Day **Physician** 2012 1:35p Monis Weaver 13, Aug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 7842 Mayfield Ave Elkridge If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ F Yrs June 6, 1936 Virginia 76 227 48 7688 Director Usual Residence of Decedent alth and Mental Hygiene.

27 Is marked other than "netural" or "".

traumalic event "". 10d Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☐ No Elkridge Director MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21075 7842 Mayfield Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2100 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Hair Salon Receptionist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; If Item 27 is marked ofth any linjury or other traumatic event, 9008. George L. Elam Elsie Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7842 Mayfield Ave, Elkridge MD 21075 Michele L. Roomets (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug.16, 12 Markham, Virginia Leeds Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moser Funeral Home, Inc. 233 Broadview Ave, Warrenton, VA 20186 CC059 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Pancreatic Cancer 3 weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 □ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hast autopsy 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No or Attending Physician: Director: After this certific tin by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No Certification: 27. Manner of Death Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide within 24 hours after To the Funerel Direct the Hospital 1 🗵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and little of certifier D0071600 0 18/95 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, 10710 Charter Dr. Suite 6020 MI) ejaswi 32. Registrar's Signature 31. Date dled (Month, Day, Year) State AUG 2 8 2012 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Dep	artment of Health and Natificate of Death		ZUIZ ZIJDJ				
			Registrar  1. Decedent's Name (First, Middle, Last)	Timcate of Death	2. Date of Death 3. Time of Death					
	Physicia Medic		Janice Marie Zabriski		0'8th 11/2012 Year ///30P M					
	Examin	er	4a. Facility Name (if not institution, give street and number)  Laurelwood Care Center	4b. City, Town, or Location of Death Elkton	4c.	County of Death Cecil				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $ 288 - 26 - 0924 $ 1 $\square$ M 2 $\raisebox{12pt}{$\mathbb{Z}$}$ F $ 79 $ Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.						
	Iryland 1-f show ied at	ctor	10a. State 10b. County 10c. City, Town or Lo  Maryland Harford Havre d			10d. Inside City Limits 1 ☐ Yes 2 🔀 No				
	a or 28a be notif	Funeral Director	10e. Street and Number	10f. Zip Code 21078		zen of What Country?				
	eath with	uner	41 Robinhood Road #505  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,				
039	ırs after de ıral", or it I Examine		Armed Forces?	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 🏋 No Specify:		Black, White, etc. Specify: White				
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation  kind of work done during most of work  OO NOT use retired)	king	nd of Business/Industry				
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Baltimore,	Page nent o ant: If ary or		4 Li Donation 5 Li Other (Specify)	iiie VA Cem08/1	Mar	yland				
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Box 68	death ne atte ed for	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year				
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ords	law requires nas been sign e 2 should bo	Completed	Ord age		24a. Was an	an 24b. Were autopsy findings available				
Rec	The ate pag				autopsy performed?	death?				
Ita	siciar certif irecto	Be c	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient	26. Place of Death (Che		Other (Cresife)				
Division of Vital Records,	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director,	icate: To	1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death  1 ☐ Inpatient 2 ☐ ER/Outpatie  28a. Date of injury (Month, Day, Year)  1 ☐ Accident Investigation			e 5 ☐ Residence 6 ☐ Other (Specify)  d. Describe how Injury occurred				
ivisio	I or Atter after des Director d in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		if. Location (Street and Number or Rural Route Number, City or Town, State)				
	the Hospital or thin 24 hours afte the Funeral Dirumpletely filled in	Medical	29a. Certifier (Check (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, death only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge.	estigation, in my opinion, death occurred	rred at the time, date and place, and due to the cause(s) and manner stated.					
•	To the within 2 To the comple	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	•		30. Name and address of person who completed cause of death (Item 23a) (Type,		FILL LOS MI	)				
	Sta		31. Date filed (Month, Day, Year)  AUG 14 2912  AUG 14 2912	17 N. Bridge St	E 1157017 191	J				
	Registr	eli'	TOU - COTE P/ begins S.	LE COLOR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G930 8/29/2012 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 State Registrar 27570 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 4:30 РΜ Jacqueline Alston August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4403 Fern Hill Avenue Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours **Director** 217-38-1307 1 □ M 2 🛛 F 71 06/13/1941 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4403 Fernhill Avenue 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) YWCA 2 Residential Counselor years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Swanson Ida Sparrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Alston 4403 Fernhill Avenue Baltimore MD.21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/24 12 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore Maryland 4 Donation 5 Other (Specify) Loudon Park Cemetery 21. Signature of uneral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Immediate Cause (Final Onse and Death Physician/ Acute venal foulure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner End-stage renal 2 years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ¥ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiple myeloma 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown plnous Diabetes mellitus type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Funeral Director: After this certificate has autopsy performed 2 🗌 No Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient R/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural 5 Pending injury hours after death. М 1 Yes 2 No filled in by the Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 24 (Check within 2

To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month. Dav. Year) F MD DC3881 August 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Javillo, MD 2435 West Belvedure Avenue, Baltimore, Maryland 21215

DHMH 17 Rev 06-2011

State

Registrar

Month, Day, Yea AUG 29

<sup>o</sup>2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:30A M Patricia August Allred 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospita Randallstown Under 1 Year If Under 24 Hrs. Baltimore 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Director 219-30-0835 1 M 2 X X F 76 Yrs Dec 6, 1935 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at withIn 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2xx No MD Anne Arundel Glen Burni 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or items 23a Funeral 504 Marley Station Rd. 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2xx Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Curtis D. Mullins Nellie Cantrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Allred Husband 504 Marley Station Rd., Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Vet. Cem Aug 10, 2012 Crownsville, MD 21. Sign ture of tuneral Service License 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy. S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END- Stage Renal Distase Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-trans Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 4 Nursing Home 5 Residence 6 Toher Specify မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskujapuheno D0057465 8/7/12

Registrar
DHMH 17 Rev 06-2011

State

5 703

Baltimore

MD

21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSKajapakseMD

31. Date filed (Month, Day, Yea AUG 292

2835 Smith AV

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Deat Physician/ Acquis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** N/A 2714 Sethlow Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Months Hours Director 1**X** M 2 □ F 223-22-0900 89 MD Jan 2, 1923 Usual Residence of Decede Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 □ No N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2714 Sethlow Road 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married δ 1 ★ Yes 2 No**10/7/1943** If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 10/13/1945 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Construction **Private Company** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic s Samuel Brown **Louise Scott** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hannah M. Brown 2714 Sethlow Road, Baltimore, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Aug 29, 2012 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** 21. Sign turn off the I Survice Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final END-Stage FENAL Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
cause Enter Underlying
Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗖 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident М Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRajapahlMD D0057465 8/24/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2835 NS Rajapa Ksemo Smith AV 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State Registrar

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imore	permit. Page 1 and 3 Det artment of Healt Important: If item 2 any injury or other		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State		nce of Dispos metery, crem <b>Arbutus</b>	atory or oth	her plac	e) k A	Date ug 06, 2012	f	Baltim		<sub>vn, State</sub> Maryland
Balt	permit Der art Import any inj once.		21. Signature of Funeral Service Licen	r. Eles		22.	Name and Est 130	Addres tep Br 00 Eut	s of Facility others Fun aw Place B	eral Service, altimore, Md	P. A. 21217			
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Q	SV		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, Pr	int)	Ba	ultimo	g re, m	D -	21	22	9
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3	Medic Examin		4a. Facility Name (if not institution, give	e street and number)			or Location of Death	0	4c. County	of Death		p•
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Baltimore,	Definit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Special Signature of Ferral Service Hicen		Aloysius	S Parish Co Name and Addre	metery 8—. ess of Facility Wy	31 <b>-</b> 2012  I Lie Fu <b>n</b> eral	ittletowr Hame P. <i>A</i>		Balto. Co	) <b>.</b>
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3	ician and		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
8760	ng physician as the burial	Medic	IF FEMALE:	d								
Division of Vital Records, P.O. Box 68760 <	y the attending place as t	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌	Ectopic pregnan Other (specify)	су		23d. Date Mor	e of delive hth	y Day Year	r
s, P.O.	been signed by the s should be detached	d by P	Part II. Other significant conditions of	contributing to death but not re-	sulting in the u	nderlying cause gi	iven in Part I.		acco use contri			- 1
Division of Vital Records,	has been ge 2 shou	nplete						24a. Was ar autops	y p	rior to con	sy findings avai	ilable se of
al Re	r this certificate has	Be Con	25. Was case referred to medical			26. P	lace of Death (Chec	perform 1 Yes 2	ned? d 2 ■ No 1	eath?	2 □ No	
f Vita	this cer ral direc	ပ	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of injury	ER/Outpatien	t 3 DOA Oth	ner: 4 ANursing H	ome 5 Reside				
o uoi	er death. e <b>ctor:</b> After t by the funera	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	(Month, Day, Year)	injury	wor	k? Yes 2 No	28d. Describe ho	w injury occurre	a		
Divis	s after deat al Director: ed in by the		4 Homicide determined			eet, factory, office		28f. Location (Str City or Town,		r or Rural I	Route Number,	
Hoeni	within 24 hours after To the Funeral Dir completely filled in	Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examinationse Practitioner: To the best of	n and/or invest	igation, in my opini	ion, death occurred a	at the time, date and	d place, and due	to the cau	se(s) and manne	er stated.
, P	withir <b>То th</b> сотпр	~	29b. Signature and title of certifier	7 -	)	29c. Licens			9d. Date signed	(Month, D		2
	ጎ		30. Name and address of person who			rint)	- 1				01 001	
	<i>∱</i> Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signa	Thos	2613	Salisb	my Mi	15 0	802		
	Registra		AUG 2 9 2012	Dereway B. 1	a auto							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2Day 2012 Catherine Barbara Boyd 08 0951 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 04/06/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2020 F 404-58-0970 89 Director Kentucky Usual Residence of Decedent the Maryland 10c. City, Town or Location show 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Harford Edgewood 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1902 Nuttal Avenue Apt.A 21040 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ed other then "natural", or event, the Maxical Examin Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: Black 3X Widowed 4 □ Divorced Completed Officers Club Aberdeen Proving Grounds 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and be filed with, and wental Hygien. .. 27 is marked other the er traumatic even? Elementary/Secondary (0-12) College (1-4or 5+) Cook 8th grade 17. Father's Name (First, Middle, Last, Be 18. Mother's Name (First, Middle, Maiden Surname) Sherman Commodore Hattie Mae Cross ပ္ 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau
once. Tanya Johnson/granddaughter 1902 Nuttal Ave.Apt.A Edgewood, MD.21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State  $09/09^{at}/12$ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Joppa Maryland Comm.Baptist Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home Cille 4210 Belair Rd.Baltimore Maryland 21206 Aful 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** FAILUKE ACUTE disease or condition resulting in death) ... /Medical Due to (or as a consequence of) **Examiner** CONGESTIVE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine HYPERTENSION PULMONARY and exect burial-tra Due to (or as a consequence of): Box 68760, physician requires that the death certificate be CHRONIC OBSTRUCTIVE POLHONARY PISTASE Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 MNo Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ DISEASE KIDNEX cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Division of Vital 1 □Yes 1 ☐Yes 2 ☐No 2. No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. e Funeral Director; After t 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1& Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 008096 drew Mowalions AVOUST 22, 2012 MIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREN NOWAKOWSKI MP 35 FULFORP AVE BELAIR, MD 2014 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Brook 1730 August homas 2012 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1928 N/A Johns Hopkins Bayview Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F 84 166-20-5480 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b County Baltimore N/AMaryland 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip-Code 21214 10g. Citizen of What Country? 3012 Beverly Road USA Funeral 2 should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 23. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No WWII 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 Yes 2 X No Specify Specify: þ 3 Wildowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Manufacture Field Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Klose Thomas Brophy ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Road Baltimore MD item 27 i Mary Brophy/Wife 20b. Place of Disposition (Name of permit. Pages 1 a
Department of Hee
Important: If item
any injury or othe
once. 20a. Method of Disposition Data 20c. Location - City or Town, State Mount Saint Marys 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 8/31/12 Emittsburg MD 21727 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Leonard J. Ruck, 5305 Harford Road Inc. Baltimore MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A, proximate rval Between Onset and Death Immediate Cause (Final State of the State of the State of Stat **Physician** Intracrania Hemor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner aumatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown the 9 Unknown · by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Hospital: 1 XInpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 🗌 No 2 ER/Outpatient 3 DOA မ completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending F after death. Director: After t 1 Natural 5 Pending investigation njury 1430 м August 21,203 subject 2 No 1 🗀 Yes 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 4 - Homicide Street Hartard Road Hamilton Koud Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 000 2012 person who completed cause of death (Item 23a) (Type, Print) 30. Name and dd 4940 Eastern Avenue, Baltimore, MD, 21224 MD heresa auo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar A. parked DHMH 17 Rev 1/2001

DHMH 17 Rev 1/20 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No 2 0 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 11:45P M BROWN August ANNA EILEEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick Year If Under 24 Hrs
Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 215-26-9022 Months **Director** 1 🗆 M 2 🗷 F MD. MAY 31, 193 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director FREDERICK FREDERICK 1 Yes 2 No MO. 10e, Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral PROSPECT 21701 BLUD 501 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working US GOVERNMENT 1 and 2 should be filed within 72 of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COMPUTER TECHICIAN 11+4 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည AMNA GERTRUDE JACKSON Louis BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAGI SHARON HAMILTON 783 Cromwell Dr. Frederick, Md. 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ Important; If if any injury or o 1 Burial 2 Cremation 3 Removal from State Aug 27,2012 Feboberen, mo FAIRVION Comorond 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LALY L. ROLLINS FUNCER ITME 21. Signature of Funeral Service Licenses Colleis my d. ST FICEOBLUR mo 23a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final Physician Congestine av disease or condition resulting in death) Medical Due to ( as a consequence of) Examiner ante Coronamy Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

☐ time of death 5 ☐ Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the a should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 \( \text{Yes} မ X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, eral Director; After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time; date and place, and due to the cause(s) and manner as stated within 2 To the I only one) the 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 08/13 MDD 67651 deress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g931 9-11-12 ye. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 27, 2012 8:20 AM Phillip Eugene Bowie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Frederick Hospita] Frederick . Social Sec**9** (9 Number 219 - <del>34 -</del> 4942 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 1 M 2 D F 72 MD NOV. 1,1939 r then "neturel", or items 23a or 28e-f show the Wedical Examiner must be notified at 10a. State 10b. County filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director FREDERICK MD. PREDERICR 1 ✓ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral MOGWOOD DR. 21701 USA 1720 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry FLOD. LTY, BA. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) STRVICE EDUCATION permit, Page 1 and 2 should be filed w Department of Health and Mantal Hygi Important: if item 27 is merked othe eny injury or other traumetic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARLES M. BOW16 MONTEREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK MD CARLLEN WIKE. BOWK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 5601, 1,200 FREDERICK MO RESTURIUM MOM. CAK. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CARY L. ROLLINS FUN HOME SOUNT ST PRED BRICK MO 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to lor as a consequence of To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant : 9 Unknown 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5V 31. Date filed (Month, Day, Year) wite 202 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 0:58A M Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death **Examiner** N/A borns Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours Min. 1**X** M 2 □ F 0972771958 MARYLAND Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1927 EASTERN AVENUE 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 🗌 Widowed 4 🗆 Divorced WHITE Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once." Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ HARLEY LAWRENCE BOOTHE DORIS D. MOODY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIDDLESEX ROAD, ESSEX, MARYLAND 21221 MARY JANE BOOTHE/SISTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 8/28/12 BALTIMORE, MARYLAND 21. Signature o Europa Service Licensee Name and Address of Eacility TLLY & ZEIL 901 EASTERN <sup>22</sup> Name a 1901 ER INC. AVENUĖ 21231 Approximate Interval Between Posefland Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Otic disease or condition Medical resulting in death) Due to fr as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Completed by Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No signed by the a ld be detached for 9 I Inknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HLOholism autopsy has certificate 1 ☐ Yes 2 ☐ No Yes No Division of Vital within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of De Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination arrows investigation, it may specified upon date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Sheila	Beatrice	Barnes
		1-1

2	0	2	2	7	5	8	

		1- For State Registrar		Cei	rtificate d	of Death				F	Reg. No	20	112		301
Physicia			Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day									Van		3. Time of Dea	ath
Medical Exami	ıer	SHEILA BEA	TRICE BA	ARNES					A	August 2	1, 20	Yea		1116 hrs	
		4a. Facility Name (if not institution Prince George's Hosp		umber)		4b. City, To Cheve		cation of	f Death			c. County o Prince G		's	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	r 24Hrs.   8	. Date of B	irth(MN	I/DD/YYYY	9. Birt	hplace (State o	or
Director		577-66-8327	1 M 2 X F	63	Y	Months rs.	Days	Hours		1/26	/194	48	Foreig Cou	n untry) DC	
Aue	- }	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Loc	ation								10d, Inside Cit	ty Limits
. ≸	٦	,	e Georges		ndover	ation								1 Yes 2	
Maryla 28a-f d at or	ğ	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of Wh	at Coun	try?	
th the 23s or		6406 Hawthorne					0785					USA			
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "matural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	/ Funeral Director	11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Div	arried Armed F  1 X Yes  rorced If Yes, Give Ye	2 No		/as Decedent Yes, specify	Cuban, M	lexican,			0-	14. Race White Specify:	etc.	an Indian, Blac ACK	<b>:</b> k,
urs af	흵	15. Decedent's Education (Spe	or Dates: . cify only highest gra	ade completed)		nt's Usual O	cupation	(Give ki			16b.	Kind of Bus			
21215-0036 uld be filed within 72 hours after Mental Hygene. marked other than "natural", c event, the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)		most of worki ter Te	-				Go	vernm	ent		
21215-003 ould be filed within I Mental Hygiene, marked other th	္စို	17. Father's Name (First, Middle, Manious Barnes	•	-			1		s Name (Fir e Lov		Maider	Surname)			
212 Jid be Menta marke	To Be	19a. Informant's Name/Relations			19b. Maili	ng Address					mber, C	ity or Town	. State.	Zip Code)	
그 유 명 프 필	_[	Sallie Hutcher	son/Mothe	er		Hawth					er,	MD 2	078	5	
ore, ML ss 1 and 2 s of Health su If item 27 her traum		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removal f		Place of Dispo crematory or o		of cemet	-		ate			,	Town, State	
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	J.	4 Donation 5 Other Sp		Was	shingto							itlan			
Bal permit Depar Impo	Ц	21, Signature of Funeral Service	Inno	$\neg$	4:	Name and A	itla:	nd R	Road S	uitla	ınd,	MD 2	074		
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the death.	. Do not enter	the mode of	dying, su	ch as ca	rdiac or res	spiratory an	rest, sh	ock, or hea	rt	Approximate Between Ons	set and
Examiner	-	Immediate Cause (Final disease or condition resulting in death)		of Ascending		eurysm A	ssociat	ed witl	h Motor	Vehicle	Collis	ion		Death	1
		Sequentially list conditions,	b	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С	a consequence of											
ecuted and transit		events resulting in death) Last	Due to (or as a	a consequence of	f):										
760, ficate be execute 3 physician and the burial - tran	//Wedical	UNPENDED	AMENDED							-					
38760, rtificate bing physic	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ne 1 Live I		2 🗌 F	etal death	3 🗌	Ectopic	pregnancy		23	d. Date of o	delivery D	ay Ye	ear
that the death certife the by the attending detached for use as	Physician		nown 9 Unkn	nant at time of de nown	ath 5 🗌 c	ther (Specif	"								
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transil	<u> </u>	Part II. Other significant condit	ions contributing t	to death but not re	esulting in the	underlying c	ause give	n in Parl	t I.					ne cause of dea ably 4 🗹 Unk	
Vital Records, P.C ysician: The law requires that his certificate has been signed director, page 2 should be deta	Completed									24a. Was				opsy findings a	
Reco	E O										rmed?	de	eath?		
an: 1	음 음	25. Was case referred to medical				26	Place of	Death (C	Check only	one)					
Vit hysici this c	اق	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DO	A Oth	her <sub>4</sub>	Nursing Ho	ome 5	Reside	ence 6	Other:		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.		27. Manner of Death  1 Natural 5 Penc 2 Accident Inves	ling 28a. Date (Month Aug 18)	e of Injury h, Day,Year) , 2012	28b. Time of 1018 hrs	· ·	c. Injury a		انتعا			ury occurre auto aut		sion	
Division  To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: A completely filled in by the fit	Certification:	3 Suicide 6 Coul	d not be 28e. Plac	ce of Injury - At ho Major Road		_	ffice build	ding, etc.		or Town, \$	State)	and Numbe t 295, Gre		al Route Numbe	er, City
DIV the Hospital or thin 24 hours afte the Funeral Di	Medical	(Ontown billy	nysician: To the be miner:On the basis	of examination a											
To vit	ž	29b. Signature and title of certifie	and manner s	siated.		29c. l	icense n	umber			29d.	Date signe	d (Mon	th, Day, Year)	
		polin &	ron Will	M		(	D.C.M.I	E.			Aug	gust 22, 1	2012		
0	Ţ	30. Name and address of person Melissa Brassell, MD	who com leted cau Assistant Me			V. Baltimo	re Stre	et. Ba	altimore	MD 2122	23				
Sta	ite	31. Date filed (Month, Day, Year)	32. R												
Regist		AIIG 2 9 2	117 /2	un A.	13000										- 1

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2758 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ 2<del>0</del>12 5:15.AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice at Northwest Hosp Randallstown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 235 48 4326 1 M 2 X F 84 01/12/1928 West Virginia 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mechan Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? Funeral 4118 Baltimore Street 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 It and Mental Hygiene. 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Zola Teter (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 Is any injury or other trau once. Richard K. Crites / Son 4118 Baltimore Street Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗌 Cremation 3 🗌 Removal from State 08/31/2012 Crestlawn Mem. Park Marriottsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Herome 4001 Ritchie Highway Baltimore, Maryland 21225 monue 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumon Medical Due f (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 100 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) Archo

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shane Carter State of Maryland / Department of Health and Mental Hygiene 2012 27582 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 24, 2012 Shane Mark Carter **Medical Examiner** 1757 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours 216 37 7790 Director 08/12/1988 24 1 AM 2 F Country) Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d, Inside City Limits Anne Arundel Glen Burnie Marvland 1 Yes 2 X No 28a-f show death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Elm Avenue U.S.A. 21061 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Framinar. White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laico Electric Co. Baltimore, MD 21215-0036 12th Apprentice Elect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donna Morseberger Gary Mark Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Schneider / Aunt 419 West Maple Avenue Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 08/30/2012| Baltimore, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Servic. Licensee manuell Baltimore, Maryland 21225 Ritchie Highway 23å. Part I. Enter the diserte, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Methadone Intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g931 9-10-12 sm X UNPENDED the attending physician ed for use as the burial of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ Other Nursing Home 5 Residence 6 Other: DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Division 1 Yes 2 X No unknown death 5 Pending within 24 hours after death To the Funeral Director: the fd 8-23-12 fd 06:00 am 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City or Town, State) **408 Elm Ave. Glen Burnie, MD.** 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide (Specify) Residence determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. R. gistrar's Signature,

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2 Physician/ Month 0 & 0503 AM Lannor mistopher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town 4c. County of Death Hashing ton Glen Da Itimore BUNK Anne Annde Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign (Month, Day, Year) Hours 219-21-6241 Director 1 **k** M 2 □ F 24 Nov. 1, 1987 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7765 Freetown Rd. 21060 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black. White, etc. 1 X Never Married 2 Married 2 ☐ Yes 2 x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Disabled N/ABe 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Yale Cannon Christina Outlaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Outlaw / Mother 2731 W. Mosher St., Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 28, Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland Funeral Service Licensee 21. Sign 22 Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., Funeral Home, P.A. S.E., Glen Burnie, MD 21061 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Opent and Death Physician/ ARDS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Rneumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Jause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 횬 1 🗌 Yes 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alliabours des Grandoch POOE5 +1A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IANGRECO 301 HOSPITAL DRIVE, GLENBURNIE, MD ZOLGI 31. Date filed (Month, Day, Year) State AUG 2 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27584 for State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast 2. Date of Death 3. Time of Death Physician/ Month Ρ. Crabtree Leona 9:00 PM 201 August Medical 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death Prince George's Regional Hospital aurel aure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 226-38-0576 Director 1 🗆 M 2 🕱 F 83 8/30/1928 Virginia Usual Residence of Dec show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director rms 23a or 28a-f sh r must be notified a 1X☐ Yes 2 ☐ No Laurel Maryland Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3397 Ft. Meade Road 20724 U. S. A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cateteria 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Prince George's Hygiene. Prince George's County Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the School System 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ည Marion Arther Lockhart Cavntha Lourana Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3397 Ft. Meade Road, Laurel, Maryland Tracey Crabtree/Son 20724 f Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or once. 8/30/2012 Waldorf, Maryland **Huntt Crematory** Signature of Funeral Service Licen 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph. sician/ evere Se Medical Due to (or as a consequence of) **Examiner** erebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) tran and that initiated events resulting in death) Last Due to (or as a consequence of): as the burial attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death for in the past 12 menths?
1 Yes 2 No Month Pregnant at time of death Day Year the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 certificate 2 🗆 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 1 Inpatient ဂ္ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 0 Van dress of person who completed cause of death (Item 23a) (Type, Print) Dusen aurel Regional Hospita Gorantla

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem 5 per fh g931 9-13-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AUQUS+ 11:15 AM Jeffrey Chivers, Jr. 23,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimork If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 0 Director 1 XM 2 F 13 Aug. 10,2012 MD Usual Residence of De ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2X No Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a United States 21117 6 Gwynnswood Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 24 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Examiner Black, White, etc ori Completed by 1 X Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) None Never Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Phillips Chivers, Sr. Faustina Jeffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, MD 21117 Health tem 27 6 Gwynnswood Rd. Faustina Chivers (mother) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 8-28-2012 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Saints Cemetery re of Fune & Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 J.Wayne Osterling 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death

4 days Physician Prematurity EXTREME Medical Examiner Growth REStriction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Bacterial Infection executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be ☐ Suicide☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Chivers

Sinai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

O'BriEn,

Thomas O'B 31. Date filed (Month, Day, Year) -0040362

2401 W. BEIVEDETE AVE.

Baltimort, md

12-06382

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

indale Carringto		State of Maryl - For State Registrar	and / Department <i>Certificate</i>		nd Mental Hy		, No. 201	2 27586
Physicia Medical Examii		1. Decedent's Name (First, Middle, Last) Lindale Carrington	-			2. Date of Death Month August 24,	Day Year 2012	3. Time of Death 1159 hrs
		4a. Facility Name (if not institution, give street and n University Hospital	umber)	4b. City, Town, o	r Location of Death		4c. County of Death N/A	1
Funeral Director	- 1	5. Social Security Number 6. Sex 12-94-6313 6. Sex	7. Age (In yrs. last birthday 33	y) If Under 1 Ye Months Da		8. Date of Birth	(MM/DD/YYYY) 9. Bir Foreig Co	
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent  10a. State	10c. City, Town or L Baltim	ore				10d. Inside City Limits
the Mary is or 28s.	Director	10e. Street and Number 669 Brisbane Rd		10f. Zip Code 2122	29	100	g. Citizen of What Cou USA	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give on Dates:	orces? 2 No ar 1	. Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto o specify:	Rican, etc.)	White, etc. Africa SpecifyAmer	
036 ithin 72 hours ne. r than "natur fedical Exam	Completed	15. Decedent's Education (Specify only highest grant properties)  Elementary/Secondary (0-12)  College (		edent's Usual Occupang most of working life Chef			16b. Kind of Business/ Green Tu	,
215-0 be filed wintal Hygie ked other	Be Cor	17. Father's Name (First, Middle, Last) Alonza W. Carrington	1		18.Mother's Name Leola	(First, Middle, Ma Carring	aiden Surname) gton	
MD 21 2 should I h and Mer 27 is man umatic ev	٤	19a. Informant's Name/Relationship (Type, Print ) Tycina R. Richardson	n/Wife 66	ailing Address (Stre 9 Brisba	et and Number or Rane Rd, B	alt.,MI	er, City or Town State	, Zip Code)
Limore, Labes I and iment of Heal trant: If item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal 1  4 Donation 5 Other Specify:	rom State Bayvie	sposition (Name of co or other place) w Cremat	ory 9/6	/12	20c. Location - City or Balt., MI	)
		21. Signature of Funeral Service Licensee	ع ا	5126 Bel	air Rd,	Balt.,M	lose F.St D 21206-	5105
Physician Wedical Examiner	8		caused the death. Do not en	ter the mode of dying	g, such as cardiac of	respiratory arres	it, snock, or neart	Approximate Interval Between Onset and Death
sit d	Examiner	cause. Enter Underlying Cause	a consequence of):					
50, te be executed ysician and burial - transit	ledical E	d.       AMENDED						
lox 6876 eath certifical attending pheron for use as the	2 1	past 12 months?	nant at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ncy	23d. Date of delivery Month	y Day Year
P.O. E es that the digned by the	ক্র	Part II. Other significant conditions contributing	o death but not resulting in t	the underlying cause	given in Part I.		acco use contribute to	
Division of Vital Records, P.C rai or Attending Physician: The law requires that rs after death.  al Director: After this certificate has been signed led in by the funeral director, page 2 should be deta	Completed					24a. Was ar autopsy perform 1 Yes 2	prior to death?	atopsy findings available completion of cause of
Vital Rec ysician: The his certificate	æ	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1	Inpatient 2 ✓ ER/Outpat		e of Death (Check of Other)		esidence 6 Other	r.
ion of \text{itending Ph}   leath. tor: After the funeral	ation: To	27. Manner of Death 28a. Date	e of Injury h, Day Year) , 2012 1100 hrs		ury at Work?	28d. Describe ho Subject stabb	w injury occurred oed	
Division  Cospital or Attend  4 hours after death  uneral Director:	Certification:	Suicide Could not be determined (Specify	ce of Injury - At home, farm,  Townhouse / Rowh	nouse		or Town, Sta 369 Brisbane R	ate) load , Baltimore, MD	
To the Hos within 24 h To the Fus completely	Medical	Check only one) 2 Medical Examiner: On the basis and manner	of examination and/or inves					
H & H ŏ	ž	29b. Signature and title of certifier Pott- Qu- Poll	Pal		se number .M.E.		29d. Date signed (Mo. August 25, 2012	
		30. Name and address of person who completed cau Patricia Aronica-Pollak MD. Assist	se of death (Item 23a) ant Medical Examine	r 900 W. Balti	imore Street, B	altimore, MD	21223	
St Regist		31. Date filed (Month, Day, Year)  ALIC 2. 9. 2012	ègistrar's Signature	Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 August 10:09 AM Alberta Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown 204 Red Ridge Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🛚 F Days Hours 12-9-1933 (ear) Country) Director 219-32-8347 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State must be notified at Director Randallstown MD Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral USA 21133 4204 Red Ridge Way filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. ıral", or iten I Examiner n 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Specify African-American Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3√ Widowed 4 Divorced "natural", the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Eastern Products Assembler of Venetian Blinds Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Morgan Page 1 and 2 should be James Shields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Red Ridge Way, Randallstown, MD 21133 Felecia E. Davis/Dauchter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 8-31-2012 MD National Cemetery Signatur Coneral Service Livens 22. Name and Address of Facility Wlie Fineral Home R.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the bunal-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the sahould be detached ☐ Yes 2 L ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Al Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29c. License number 29b. Signature and title of certif

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		aryland / De C	partment of I ertificate of I	Tealth and N Death	/lental Hy	giene Reg. No. 201	2 27588
	sicia: ledic:	al	1. Decedent's Name (First, Middle Barry D	ifferdal				2. Date of De Month Au らっらて	Day Yea	3. Time of Death
Ex	amine		4a. Facility Name (if not institution, Northwest Hos	give street and number)		4b. City, Town, o	r Location of Death		4c. County of Di Balt	eath MOCK
Fun Dire	_		5. Social Security Number  217-56-4785  Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	(In yrs. last birthda 64 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 06/06/	y, Year)	Birthplace (State or Foreign Country) Maryland
Ind 21215-0036  Filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show	st be notified at	ral Director	10a. State 10b. County MD Balti 10e. Street and Number		10c. City, Town or Catons	7111e			10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 🛣 No Country?
21215-0036 within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho	cal Examiner mu	eted by Funeral	725 Crosby Roa  11. Marital Status  1 🖾 Never Married 2 🗆 Marr  3 🗀 Widowed 4 🗀 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 X	No	1 ☐ Yes 2 🕱 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	hite
21215-0036 within 72 hours after giene. her than "natural", o	t, the Medi	Completed		St grade completed)  College (1-4 or 5-	(Giv	cedent's Usual Occup re kind of work done of DO NOT use retired) Dartment M	during most of work	ing	16b. Kind of Busine:  Retail (	,
Maryland 2- 2 should be filed wit Ith and Mental Hygie 27 is marked other:	atic even	To Be	17. Father's Name (First, Middle, L Francis Sco		•		18. Mother's Name Doris	e (First, Middle, Ply	Maiden Surname)	
	her traum		19a. Informant's Name/Relationsh Ronald S. Dif		ther 981	1 Hickory			r, City or Town, State, ttingham,	
Page nent c	jury or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 ☒ Donation 5 □ Other (S	3 ☐ Removal from State	cemetery, ci	position (Name of rematory or other place Gifts Regist	ce)	Date 8/2012	20c. Location - City Hanover, 1	·
Balt permit. Departr Imports	any in		21. Signature of Funeral Service L		`		elley Dr.	, Ste.		gistry , MD 21076
Physici Med	_		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line.	hythmia	nter the mode of dyin	g, such as cardiac c	or respiratory arr	est,	Approximate Interval Between Onset and Death
Exami	ner	_ 	Sequentially list conditions,		cons quence of):	neart f	ailure			
secuted	in-trainsii	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	neart f	yeas.e			
8760 ifficate be executed on g physician and		edical		d						
box 6 death cert he attendir	acine to total		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 Pregnant at 9 Unknown	Fetal death 3	Cother (specify)	у		23d. Date of o	delivery Day Year
is, P.O. uires that the n signed by the left had be detected.		d a pa	Part II. Other significant condition	ns contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.			to the cause of death?
UNISION OT VITAL HECONDS, all or Attending Physician: The law requires s after death.  In Director: After this certificate has been sign in the funce of director representations.		omplet						24a. Was a autop	sy prior to med? death	
cian:			25. Was case referred to medical examiner?	Li-		26. Pla	ace of Death (Check	1 \(\superstack Yes\) only one)	ZINO ILI	′es 2 □ No
Physic this c		<u> </u>	1 Yes 2 No	Hospital: 1 ☐ Inpatier 28a. Date of injury	nt 2 ER/Outpati		4 L Nursing Hor		ence 6 Other (Spe	ecify)
ttending death. tor: After		Certificate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n	g (Month, Day,	Year) injury	M 1 🗆		28d. Describe h	ow injury occurred	
DIVIS			4 Homicide determin	building, etc.	(Specify)	treet, factory, office		City or Tow		
e Hosi 24 ho e Fune		Medical	(Check 2 L. Medical E)	Physician: To the best of m kaminer: On the basis of exa Nurse Practioner: To the b	imination and/or inve	estigation, in my opinio	n, death occurred at	the time, date ar	nd place, and due to the	e cause(s) and manner stated
To th To th									29d. Date signed (Mor	ith, Day, Year)
		3	30. Name and address of person w (M: Luce) 11. Date filed (Month, Day, Year) AUG 29	ho completed cause of dea	ath (Item 23a) (Type,	Print)	tal ER-T	,		
	State istrar	3	1. Date filed (Month, Day, Year) AUG 29	2012 32. Egiotres:	s Signature	arke				
DHMH 17 Rev		9	1100 40		- h. H		ř			
-	-				ORIGI	NAL	13			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amned #1 State of Maryland Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) Rodger Patrick Doody 2. Date of Death Physician/ Month Roger Patrick Doody August 26 7:05  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northhampton Manor Health Care Ctr. Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8 Date of Birth Min (Month, Day, Year, Hours Director 220-16-0211 1 ★ M 2 □ F 86 7/24/1926 MD r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21701 200 E. 16th St. United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than " any hiury or other traumatic event, the MeagnGe. Elementary/Secondary (0-12) College (1-4 or 5+) Dairy Farmer Agriculture 7+6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Doody, Sr. Bertha Alice Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11306 Mountain View Rd. Damascus, MD 20872 Jo Anne Leatherman (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 8/28/2012 Winfield, MD 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final erebro Vasculan Physician Acciden disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and for use as the burial-transi Hospital or Attending Physiclan: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐼 No ျု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 ☐ Certifying N rse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 801

TOLL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. F

aids

31. Date filed (Month, Day, Year)

8.27-12

House Are, Frederick MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ England Η. AUGUST Re11a 3:00 P.M 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE ROSEDALE BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-34-5205 Director 1 🗆 M 2 🕱 F Nov. 21,1935 Maryland 76 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Middle River Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 1322 Fuselage Avenue United States 21220 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) Shipping and Receiving Bindery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richmond NGLAND Ruth Charles Hall injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Timothy Corbin (Son) Middle River, MD 1322 Fuselage Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 8/30/2012 M∉adowridge Mem. Park Elkridge, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Fisher 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TATUS disease or condition resulting in death) EPILEPTICUS Medical Due to (or as a consequence of) Examiner HEPATIC Sequentially list conditions Examiner it any leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LUNG TASTATIC the burial-tran Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number Asuma RES 0000 Kaluman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAHMAN 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237 ASIMA 31. Date filed (Month, Day, AUG 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ravis B. Fleet			ate of Marylan	id / Depar	tment of	Health and			-	12 2759
Physici	an/	Registrar 1. Decedent's Name (First, Midd	le.Last) magazi a		ificate of		-	2. Date of Dea	eg. No. 20 th	3. Time of Death
Medical Exami		Travis B.	Fleet,	ъепјаші <del>Sr</del> .	п гтее	L, DK.		Month August 18	Day Year 3, 2012	1925 hrs
4		4a. Facility Name (if not institution			- 4	b. City, Town, or	Location of Dea	ath	4c. County of	Death
x x x x	н	2409 Ridgley Street	6, Sex 7.	Age (In yrs. las	t histhstory)	Baltimore  If Under 1 Year	Kunder 24L	Iro. I O Dato of Bir	N/	A  9. Birthplace (State or
Funeral Director		5. Social Security Number	!			Months Days		lin.	`	Foreign
		218-90-2308 Usual Residence of Decedent	1 X M 2 F	43	Yrs.			9/29/	1968	Country) MD
any		10a. State 10b. County		10c. City, T	own or Location	on				10d. Inside City Limits
Aaryland 28a-f show	ō	MD Bali	timore Ci	t <b>y</b> B	Altim					1XX Yes 2 No
Maryl r 28a-	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country?
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must he notified at ouce.		2409 Ridgely			Lacus	21230	. 6		USA	
eath w	Funeral	1 Never Married 2 M	arried Armed Forc			s Decedent of Hisp es, specify Cuban,		Specify Yes or No to Rican, etc.)	White,	American Indian, Black, etc.
fler de		3 Widowed 4 X Div	1 Yes	2 <b>X</b> No	1	Yes 2X No	specify:		Specify:	Black
ours a	ğ p	15. Decedent's Education (Spe				's Usual Occupati			16b. Kind of Bus	
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5-0036 Iled within 72 hours Hygiene. d other than "natur	Completed	12 17. Father's Name (First, Middle,	Last)		Fuel	Engine		me (First, Middle, M	BW I Maiden Surname)	
21215-0036 vald be filed within 7 Mental Hygiene. marked other than	Bec	Benjamin H.					Oli		eet	
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re, MD 1 and 2 shc Health and fitem 27 is		Vonda Fleet 20a. Method of Disposition		205 PI	2331	Annapol	lis Ro	ad, Bal	timore,	Md. 21230 City or Town, State
Baltimore, MD 2 oemit. Pages I and 2 shoul Department of Health and N important: If item 27 is m injury or other traumatic		1 Burial 2 Cremation	n 3 Removal from	State cre	ematory or oth	er place)				•
Baltimore permit. Pages 1 Department of H Important: If in	- 1	4 Donation 5 Other Sp 21. Signature of Funeral Service	Decify:	Mt.	Zion	Cemete	ery 8/2	28/2012	Lansdo	owne, Md.
Ba permi Depa Impo injur	ļ	21. Signature of Funeral Service 23a. Part. Enter the disease, or	956	0	Es	tep Bro	thers	Funera	1 Servi	ce, PA Md. 21217
Physician	$\dashv$	23a. Part Enter the disease, or	complications that caus	sed the death. D	o not enter th	e mode of dying,	such as cardiac	or respiratory arre	est, shock, or hear	t Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	77	xycodor	ne, and	l Alprazo	olam In	toxicatio	on	Between Onset and Death
LAGIIIIICI		or condition resulting in death)	Due to (or as a co							·
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ited d ansit		events resulting in death) Last	Due to (or as a co	nsequence or):						
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760, cate be physic he bur	ĕ.	IF FEMALE:		come of pregna	ncy				23d. Date of d	elivery
68 certifi anding use as	ian	23b. Was decedent pregnant in the past 12 months?	I Live billi	n t at time of death		al death 3 L	Ectopic pregi	nancy	Month	Day Year
Box 68760, e death certificate by the attending physical for use as the but	Physician/Me	1 Yes 2 No 9 Unk	known 9 Unknown		□ Oth	er (Specify)				
F, P.O. ires that the signed by the detache		Part II. Other significant condit	ions contributing to de	eath but not resu	alting in the ur	iderlying cause gi	ven in Part I.	23e. Did to		ute to the cause of death?
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cords law requi	plet							24a. Was a autop:	sy pri	ere autopsy findings available or to completion of cause of
Rec The  z	Completed							1 ✓ Yes		ath? ✔ Yes 2 No
Division of Vital Records, talor Attending Physician: The law requir is after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the fineral director, page 2 should the fineral director.	Be (	25. Was case referred to medical examiner?	Hospital:				of Death (Chec Other Nurs			
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Dipital ours all filled in	Certification:	4 Homicide deter	mined (Specify)	found at	t home			Baltimo	re,MD.	idgley St.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		(Oneon only	nysician: To the best of miner:On the basis of e	-			•			
To To Com	Medical	29b. Signature and title of certifie	and manner state	ed		29c. License	number		29d. Date signed	(Month, Day, Year)
		D-2 DI				O.C.M	1.E.		August 19, 2	
_	-	30. Name and address of person	who completed cause of	of death (Item 23	Ba)				L	
	_	Donna M. Vincenti, MI	O Assistant Med	dical Examir	ner 900 V	V. Baltimore	Street, Balti	more, MD 21	223	
St Regist		31. Date filed (Month, Day, Year)	2012	trar's Signature	-1-	7,				
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AMEND Item#29c perDVR C930 8730/2012 WS
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 2012 Alease Ferguson 22 :55a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Power Back Health Care Center Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) (Month. Day, Year) Director 212-48-1158 1 □ M 2**X** F 65 07 18 47 Usual Residence of Decedent filed within 72 hours after death with the Maryland ral Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Evan Inc. must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4803 Tamarind Road 21209 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. δ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2√√2 No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Depertment of Health and Mental Hygier Important: If item 27 is marked other to any Injury or other traumatic event, the Once. 2th grade Laborer Various Jobs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Ferguson Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ross-Friend 4901 Herring Run Drive, Baltimore, Md 21214 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) 8/25/2012 Zion Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility arch F/H West Baltimore, Md 23a. Pait 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical <sup>'</sup>Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the dornal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day ours after death. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Donth 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled In Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ned (Month, Day, Year) D56775 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bri

State Registrar

12-06370		or Print in Black Inc				le.	
Robert Lynn Foste	1- For State Registrar		rtment of Health ar tificate of Death		Reg. N	0.	2759
Physician Medical Examine	Robert L. Foste	r		1	Date of Death  Month Day August 23, 20	/ Year	3. Time of Death 2012 hrs
	4a. Facility Name (if not institution, give Laurel Regional Hospital	e street and number)	4b. City, Town, o Laurel	or Location of Death		4c. County of Death Prince George'	s
Funeral Director	5. Social Security Number 6. S		st birthday) If Under 1 Ye  Months Da		8. Date of Birth(Mi	M/DD/YYYY) 9. Birth Foreign	1
Director	218-94-3005 1 Usual Residence of Decedent	]M 2□F 46	Yrs.	,0 110410 1111111	12/18/1	.965 Cou	<sup>ntry)</sup> Maryland
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death wi	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 X No		ispanic <b>O</b> rigin? ( Spec an, Mexican, Puerto Ri		14. Race - America White, etc.	an Indian, Black,
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	12 17. Father's Name (First, Middle, Last		Carpenter	18.Mother's Name (F		Remodeling	
1215 I be file ental Hy arked o	Robert C. Foste	r		Lois Ba	ırnard		
AD 21 2 should h and Me 27 is ma matic ev	19a. Informant's Name/Relationship (TDale Holmes/Step-		19b. Mailing Address (Stre				Zip Code) 20763
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Ba Commission by Eliment Director	20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State 20b. Pi	ace of Disposition (Name of co	emetery, D	Date 20c	. Location - City or T	own, State
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Balt permit. Depart Import injury	Jos f. Foris	3	7601 Sandy	Spring Ro	ad, Laur	el, MD 2	0707
Physician /Medical	23a. Part I. Enter the disease, or comp failure. List only one cause on ea		Do not enter the mode of dying	, such as cardiac or re	espiratory arrest, sh	hock, or heart	Approximate Interval Between Onset and Death
Examiner		Due to (or as a consequence of):					
100	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of)	:				<u> </u>
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D. Box 68760, the death certificate be eby the attending physicial by the attending physicial sched for use as the burial Physician/Medit	past 12 months?	1 Live birth 4 Pregnant at time of deat	2 Fetal death 3 th 5 Other (Specify)	Ectopic pregnancy	' I	Month Da	y Year
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cord law req has bee e 2 shou					24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
Vital Rec ysician: The l his certificate b director, page	25. Was case referred to medical		26.Plac	e of Death (Check only		No 1 Yes	2 No
FVita Physici er this corral direc	examiner? 1  Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 2 V E		Other Nursing H		dence 6 Other:	
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Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificatic	4 V Homicide	an: To the best of my knowledge	e, death occurred at the time, d			nd Street, Laurel, N	
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ONN	hy w	~ ~		M.E.		Date signed (Monti gust 24, 2012	., Day, (Gai)
17/1.	30. Name and address of person who deling Li, MD Assistant M	completed cause of death (Item 2 edical Examiner 900 W		timore MD 2122	3		
State		32. Registrar's Signature					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frances I. Flanagan 2012 4:30 A August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore County 4b. City, Town, or Location of Death Examiner Parkville 8844 Wilson Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Days Hours Min Jan. 17, Year 1947 Marwiand 218-44-7324 65 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 8844 Wilson Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married þ 1 Yes 2 2 X No 1 Yes 2 X No Specify: White Specify: 3 Divorced 27 is marked other than "natural" Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Flanagan Enterprises Secretary Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Albert Greaver Lucille Butta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George M. Flanagan/Husband 8844 Wilson Avenue Baltimore MD Health permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once, other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/29/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Leonard J. Ruck Inc. Balto. MD 21214 Signature of Funeral Service License 5305 Harford Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on add line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) an Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Ridgley CHoice Cause (Disease or linjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 ☐ Yes 272 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Weaver 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician: The 1 Yes 2 No 1 ☐ Yes 2 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home S Residence 6 Other (Specify) Johnson 2 200 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 41614 28,2012 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 100 21286 1 cuscus uus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	Armed For	2 🔼 No			fy Cubar	spanic Origin? (S n, Mexican, Puert Specify:				ck, White	rican Indian, e, etc. ite	
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Page 1 an nent of He ant: If iten ary or oth		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Ctoto	Place of Disponentery, cres	matory or of	her place	e) 8/	Date 30/12		Location 11tim	-	Town, State MD	
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Medical Examiner		disease or condition resulting in death)	Due to (	or as a conseq	uence of):	)								
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To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Cheek 2 Medical E	Physician: To the be xaminer: On the bas Nurse Practioner:	is of examinatio	n and/or inves	stigation, in r	ny opinio	n, death occurred	at the time, date	and pla	ce, and du	ue to the	cause(s) and n	nanner stated.
To the within To the compl	Σ	29b. Signature and title of certifier	Nurse Fractioner.	To the best of the	y Kilowiedge,		License			29d. [	Date signe	ed (Monti	n, Day, Year)	
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	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of De	ath
-angrés	<u></u>		10 STONE PINE COURT  5. Social Security Number	ge (In yrs. last birthday)	BALTIMO	ORE If Under 24 Hrs.	8. Date of Bir	BALTIM	
	Funeral Director		094-22-0242   1 X M 2 □ F   7. A	ge (iii yrs. last biitiloay) 82 Yrs.	Months Days	Hours Min.	04/18		irthplace (State or Foreign ountry)  NY
	T OM		Usual Residence of Decedent  10a. State 10b. County				<u>'</u>		Lauren
	ırylanda-f sh	Director		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	he Ma or 28a		MD BALTIMORE  10e. Street and Number	BALTIMO	10f. Zip Code			10g. Citizen of What	
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ary	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State, 2	
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ore	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	-	natory`or other plac		Date	20c. Location - City	
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	To th withir To th comp		29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mor	th, Day, Year)
			Thomas J Smith my		MD	D3324	9	August	27, 2012 OCK BALTI VEST MURE
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27597 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ August 24<sup>Day</sup> 2012<sup>Year</sup> Albert Johnny Finch 1750 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2900 Mallview Road n/a Baltimore Social Security Number 9. Birthplace (State or Foreign MD untry) 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 XM 2 - F Months Min 09/15/1930 135-22-8678 81 Director Usual Residence of Decedent 28a-f shov 10a. State ural", or items 23a or 28a-f sho I Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2900 Mallview Road 21230 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1.951-53 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 → No Specify: "natural", Specify:Black Completed 3X Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mail Handler US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Brown Lillie Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl tment of Health a tant: If item 27 is jury or other tra Darryl Warren- Nephew 2900 Mallview Rd Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) Carrison Forest VA Cem 09.04.2012 Owings Mills, MD Funeral Se FORITCE John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 Pal 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Renal tallure Medical resulting in death) Due to (or as a consequence of) Examiner Menths cancer Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burialending physician use as the burial Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy ate 2 🗌 No 1 Tes 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\nearrow$ Residence 6  $\square$  Other (Specify) 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 2 Accider 3 Suicide injury 5 Pending e Hosphan n 24 hours after death. he Funeral Director: Aft Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 11ctoria Steiner-L Year, Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 8 2012

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only one) 29b. Signature and title of certifie

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0/0

29c. License number

Frederick Nd #18,

29d. Date signed (Month, Day, Year)

Baltimore. 14. 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 904 AM Edward Gibson, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Funeral . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Min. Days Hours (Month, Day, Year) Jan 9, 1936 MD Director 217-30-4921 76 show 10a, State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director X 1 Yes 2 No 28a-f **Baltimore Baltimore City** MD 10e. Street and Number 5 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 21215 U.S.A. 4201 Elderon Avenue death \ or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 2 Na1/16/195 Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black "natural", 3 Widowed 4 ☐ Divorced If Yes, Give Specify: Completed 9/16/1960 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Royal Cab Company Dispatcher 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Marielle Rice Edward Gibson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 4201 Elderon Avenue Baltimore, MD 21215 Ruth Reynolds 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place)

Crownsville Veterans Cemetery X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 27, 2012 Crownsville, Md. 4  $\square$  Donation 5  $\square$  Other (Specify) 21. Signatur of uneral Service Licenses 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ -40 min disease or condition Medical resulting in death) Examiner Unknown Sequentially list our ditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 After this certificate has death? 2 KNO 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 XNo 1 Yes ည 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending 2 No Funeral Director: A etely filled in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) H72243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Date filed (Month, Day, Year)

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

yeu n. Omam		1- For State	•	inent of neath ficate of Death	iu Mentani	-	201	2 2/59
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	001111	Todio of Dodin		Reg. N 2. Date of Death		3. Time of Death
Medical Exam		Syed Ars	had	Gillar	ni	Month Da August 26, 20	y Year 012	2108 hrs
		4a. Facility Name (if not institution, give street and nu	mber)	4b. City, Town, o	r Location of Death		4c. County of Death	1
		Easton Memorial Hospital		Easton			Talbot	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last I	birthday) If Under 1 Yea  Months Day		Η `	M/DD/YYYY) 9. Bir Foreig	n
Difector		214-67-7779 1XM 2_F	53	Yrs.		12 02	58	untnPakista
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
. ≜		MD Montgomery	Co	ithersburg				1 Yes 2 No
Maryland 28a-f show d at once.	Sch	MD Montgomery  10e. Street and Number	Ga	10f. Zip Code		109. (	Citizen of What Cour	
the M	Director	7932 Ottercove Ct.			20886	Pa	kistan	
and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.  eath and Mental Hygiene.  tem 27 is marked ruther than "natural", or items 23a nr 28a-f shorraumatic event, the Medical Examiner must be notified at once.	Funeral		edent Ever in U.S.	13. Was Decedent of Hi				can Indian, Black,
r death or ite	Š	1 Never Married 2 Married Armed Fo	2 X No	If Yes, specify Cuba		Rican, etc.)	White, etc.	
s after	þ	Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X No				asian
2 hour	Completed	15. Decedent's Education (Specify only highest grad  Elementary/Secondary (0-12) College (1		<ul> <li>Decedent's Usual Occupa during most of working life</li> </ul>			o. Kind of Business/l	ndustry
336 thin 72 than than	ple	Bth grade na	40.01)	Attendant		s	hell Gas	s Company
5-0C ed wit tygien ather	Cou	17. Father's Name (First, Middle, Last)			18.Mother's Name	(First, Middle, Maid		
21215-0036 out be filed within 7 is Mental Hygiene. Is marked uther than is event, the Medica	Be	Syed Akbar Gillani			Azir	Bibi		
21 hould hould Me is ma	2	19a. Informant's Name/Relationship (Type, Print )		19b. Mailing Address (Stree	et and Number or R	tural Route Number,	City or Town, State	Zip Code)
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours afte nt of Health and Mental Hygiene.  tt If item 27 is marked nither than "natural", other traumatic event, the Medical Examiner.		Safdar Khan-Friend 20a. Method of Disposition		7015 Cypres				
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		1 X Burial 2 Cremation 3 X Removal free	m State crem	natory or other place)			c. Location - City or	
tim : Pag tment runt:		4 Donation Other Specify	Gu	jrat	9/3	3/2012 <sub>G</sub>	ujrat, 1	Pakistan
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If iten 27 is minjury or other traumatic.		21. Signature of Funeral Service Licensee	1	<sup>22</sup> Mame and Address 4300 Walt	MFaWEst	. Balti	more. Mo	3 21215
Physician		23a. Part I. Enter the disease of complications that ca	used the death, Do					Approximate Interval
(Medical.	: 7	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclere	otic Cardiovaso	cular Disease				Between Onset and Death
Examiner		and the second second	consequence of):	Joidi Diocaso				
		Sequentially list conditions, b						
	Examiner	cause. Enter Underlying Cause	consequence of):					ļ
, S	хап		consequence of):	· -				
and and transit	<u>e</u>	d.	18 per f	P	7 774	<u>.</u>		
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - trai	Medical		20a, perFi	<b>h, 6930, 87397</b> 2	σ12, ws			
876 ificate ig phy	ξ	23b. Was decedent pregnant in the	utcome of pregnand th	cy Fetal death 3	Ectopic pregnar		23d. Date of delivery Month	ay Year
X 61	icia	past 12 months?	nt at time of death	5 Other (Specify)		,	mona.	ay Tour
Bo le deal the at	Physician/	1 Yes 2 No 9 Unknown 9 Unknow						
, P.O. res that the signed by be detach	P P	Part II. Other significant conditions contributing to	death but not result	ting in the underlying cause of	given in Part I.		o use contribute to t	the cause of death?  ably 4  Unknown
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cords aw requi	Completed					autopsy performed	prior to co	ompletion of cause of
tal Rec	ទូ					1 Yes 2	No 1 ✓ Ye	s 2 No
certif	Be	25. Was case referred to medical examiner?			of Death (Check of Other, Nursing			
of Vig Physical Citer this neral div	٢	1 <b>✓</b> Yes 2 No	patient 2 V ER/			Home 5 Resi	dence 6 Other:	
ion of tending Pl eath. or: After the funera	Certification:	27. Manner of Death  1   Natural 5 Pending  28a. Date of (Month,	Day, Year)	I man	Yes 2 No	zod. Describe now i	njury occurred	
isic	icat	2 Accident Investigation 28e Place	of Injury - At home,	, farm, street, factory, office b	ouilding, etc.	28f. Location (Street	and Number or Rur	al Route Number, City
Div pital or ours afte	ertit	3 Suicide 6 Could not be determined (Specify)				or Town, State)		,
Hosp 24 hou Fuoc rely fi		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, d	death occurred at the time, da	ate and place, and	due to the cause(s)	and manner as state	d.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of and manner sta		r investigation, in my opinion	, death occurred at	the time, date and p	place, and due to the	cause(s)
PSPS	ž	29b. Signature and title of conflier	>	29c. Licens		290	I. Date signed (Mon	th, Day, Year)
		ath Ben & M		O.C.I	M.E.	Αι	gust 27, 2012	
3	Ì	30. Name and address of person who completed cause	,	,	troot Dellin	• MD 04000		
			istanda Cimatura	900 W. Baltimore S	ueet, Baltimor	e, MD 21223		
St Regist		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	1.1				
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DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #20b Per FH G931 9/18/2012 JH
State of Maryland / Department of Health and Mental Hygiene 20 1 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** August 2012 0856 AM 25 6W2 all /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, 11/14/ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 M 2X F S.Carolina 1928 249-40-5445 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heath and Mental Hygiene.
nt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 X Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21206 4710 Furley Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ò 3 ♥ Widowed 4 Divorced Completed 16b. Kind of Business/IndustryDept.of Human Resource 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) D.C.Government Housekeeper 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Coates Murel Phillips ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria Allison/daughter 4507 Sipple Avenue Baltimore Md.21206 permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 9/20/2012 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Va. Arlington Nat't Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-harris Funeral Home 4h 4210 Belair Rd.Baltimore Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovasc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 3.No has 2 🗌 No 1 ☐ Yes 1 🗌 Yes certificate 25. Was case referred to medical examiner?
1 X Yes 2 □ No 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Inpatient 3 DOA ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident Injury 1 🗌 Yes 2 🗌 No death. filled in by the 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical (check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 25 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EAR 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perPHYS#30perDVR, G930, 8/29/2012, WS#2
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#7,8, perFH, G931, 9/18/2012, WS

Certificate of Death

Reg. No. 2012 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 355 PM Physician/ Jalind TUCVICL AUG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
RUSSIA 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1931 1 M 2 XX Months Days Month Da Day, 219-21-2086 -94 Director 81 Usual Residence of Decedent 18. 193 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3 RUSSERN COURT; APT. 1-D 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give X Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE Completed 3XXWidowed 4 □ Divorced Specify: Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. the HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 NIKOLI KOZLOV ANNA UNKNOWN traumatic je 1 and 2 should by t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. ROMAN GURVICH / SON 1503 CARRIAGE HILL DR; WESTMINSTER, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State BALTIMÓRE HÉBREW 8-26-2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee May Levi 8900 REISTERSTOWN RD: BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arthero scieratic cardiovascular disease Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to inneclate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence. the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No completed filled in by the funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5  $\square$  Pending iniury Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Maching Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 23,2012 D0063918 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road Dionne Smith Baltimore, MD. 21133 Que 32. Regist State Registrar

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Joel Philip Goldbe	-	For State	State	of Maryla	nd / Depa	artment of	Health Death	and	Menta	al Hyg		ea No	201	2	27602			
Physicia		1- For State  Certificate Of Death  Reg. No.  Registrar  1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year								me of Death								
Medical Examin	er	JOEL PHIL		GOLDBE							August 23	3, 2012			604 hrs			
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5706 45th Avenue 4c. County of Prince Ge																
- Faranzi	4	5. Social Security Number	6. 5	Sex	7. Age (In yrs. la	ast birthday)	If Under		If Under	24Hrs.	8. Date of Bi	rth(MM/DI	D/YYYY) 9. E	Birthpla	ce (State or			
Funeral Director		524-66-3652		X M 2 F	60	) Yrs.	Months	Days	Hours	Min.	05/29	/1952	2 Fore	ountry	CO			
	ŀ	Usual Residence of Decede												1104	Inside City Limits			
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	DANTEL  19a. Informant's Name/Rela	tionship		DBERGEI	19b. Mailing	Address	(Street	IDA and Numl	ber or Ru	ıral Route Nu	_	y or Town, Sta		Code)			
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury nr nther traumatic event, the Medical Examiner m	۵[	MARSHA GOLD			'E							LE,	MD 207	81				
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Baltimore, Semit. Pages I as Department of He Important: If ite	ı	21. Signature of Funeral Se	rvice Lic	ensee #		22. N	lame and	Address	of Facility				& BROS					
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Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Death																
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):																
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ed nsit	Examine	events resulting in death)		Due to (or as a	consequence	of):												
executed an and al - transit	dical	UNPENDED		AMENDED														
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Med	IF FEMALE:	4 1- 41-		outcome of pre				7				Date of deliv		Year			
687 certific	ian/	23b. Was decedent pregna past 12 months?	nt in the	1 Live b	oirth nant at time of d		tal death ther (Spec	3 [ cifv)	Ectopic	pregnar	ıcy		Month	Day	, eai			
Box 68760 e death certificate b the attending physied for use as the bu	Physician/Me	1 Yes 2 No 9	-	3 Oliva							1				and of death?			
bat the	by Pt	Part II. Other significant	ondition	s contributing to	o death but not	resulting in the	underlying	cause g	iven in Pa	art I.					cause of death? y 4 Unknown			
Division of Vital Records, P.C ral or Attending Physician: The law requires that is after death.  **I Director: After this certificate has been signed led in by the funeral director, page 2 should be deat											24a. Wa		24b. Were	autop	sy findings available			
cords, aw requii has been 3	Completed				<del></del>						per	opsy formed?	deatl	1?	oletion of cause of			
ital Recor	Sol		1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 26 Place of Death (Check only one)															
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to rexaminer?  1 ✓ Yes 2 N		Hospital: 1	Inpatient 2	ER/Outpatien		ОА	Other		g Home 5	Reside	nce 6 🗸 O	ther: So	ene			
1 of Viring Physical After this funeral direction	$\vdash$	1 ✓ Yes 2 N 27. Manner of Death		28a. Date	of Injury Day,Year)	28b. Time of	Injury	-	y at Work	. 19	28d. Describ Subject in	e how inju haled a	iry occurred uto exhau	st fun	nes			
ion teath. tor: A	atio	1 Natural 5 2 Accident	Pendin Investi	gnation Aug 23	2012	FOUND: 1558 hrs			res 2 ✓	No	•				Route Number, City			
ivis lor Al after d Direc d in by	Certification:	3 Suicide 6	Could i	not be		home, farm, stre se / Rowhou		, office b	uilding, et	- 1	or Town	. State)	Hyattsville, I		Rodie Number, Oity			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide		sician: To the be				e time, da	ate and pla									
the H thin 24 the F mplete	Medical	(Check only one) 2  Medic	al Exam	iner:On the basis	of examination	and/or investiga	ation, in m	y opinion	, death oc	ccurred a	t the time, da	ite and pla	ace, and due t	o the c	ause(s)			
<b>5</b> 1	Me																	
		O.C.M.E. August 24, 2012																
()	ļ į	30. Name and address of			use of death (Ite Medical Exa		) W. Ba	ltimore	Street	Baltin	nore, MD	21223						
8	tate	Donna M. Vincer  31. Date filed (Month, Da)		32. R	egistrar's Signa	ature												
Regis			292	012	aur 1	1. par	Na.											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AUGUST Physician/ 2012 09:42P M LOUISE GRUNWALD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3704 N. CHARLES STREET, N/A#1602 BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🏻 117067 1926 219-28-9156 85 Yrs MD Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3704 N. CHARLES STREET, #1602 21218 USA 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married ģ 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygiene
27 is marked other the traumatic event, the RESEARCH ASSISTANT MEDICAL Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. ROMBRO JACOB ELYSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALE GRUNWALD / DAUGHTER 101 VININGS PARKWAY, SMYRNA, GA 30080 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/26/2012 BALTIMORE HEBREW REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner LERODERM Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) rsician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 month Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy death? 1 Yes 2 No 1 Yes 2 25. Was case referred to medi 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: I Director: After the in by the funeral 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Natural M Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier mineromas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY M NEWMAN , MD 1075 MP RD + 200 LUTHERVILLE

DHMH 17 Rev 7/2009

State Registrar MARY

M

31. Date filed (Month, Day, Year)

10755

FALLS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Month 6:03 P.M Evelyn May Haynie August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6508 S. Charter Road Anne Arundel Apt. A Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours 0870171922 Country)Maryland 90 214 14 3330 **Director** Usual Residence of Decedent or 28a-f show 10b. County of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director N/A Maryland Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3725 St. Victor Street 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Trucking 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be t. Department of Health and Mental. Important: If item 27 is many injury or other. ပ Roy E. Davidson Margaret J. Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Mitchell / Daughter 6508 S. Charter Road Apt. A Glen Burnie, MD. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Glen Haven Mem. Park 108/30/2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or comp shock, or heart failure. List soly of cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nset and Death Immediate Cause (Final ER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) <del>Daughter's</del> Home examiner? 2 No Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print

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1)45105

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav HARMAN ILDR 3-012 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Frederick Villa Nursing Home Baltimore Catonsville If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Months Days 1 ☐ M 2 🗓 F 93 215 07 1671 04/12/1919 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 □Yes 2 V No Anne Arundel Glen Burnie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 902 Broadview Blvd. 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Specify. 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Tharle Ella Haas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Eldersburg, Maryland 21784 1919 Gardina Street Ronna Lefebvre / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Meadowridge Mem. Park 8/27/2012 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature Fineral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HHEROSCLEROTIC EREBRO VARCO Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unkno Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably DISEASE 24b. Were autopsy findings available prior to completion of cause of death? RIERY 24a. Was an autopsy performed 2 No 1 Yes 12 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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2

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-trar physician the as attending asn for the hed ed by t signed b

certificate has b irector, page 2 s the Hospital or Attending Physician: director After this

Division or Vital Records, P.O. Box 68760,

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

31. Date filed (Month, Day, Year)

AUG 2 9 2012

Natural

29a. Certifier

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c. License number 29b. Signature and title of certifier

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28595

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525 OWNERS MILL MA SNEEM

28a. Date of Injury (Month, Day Year)

State Registrar

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hn Willis Hickle	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death  Reg. No. 2012 27606								
Physician/ edical Examiner	1. Decedent's Name (First, Middle,Last)  John Willis Hickl	2. Date of Death  Month Day Year August 24, 2012  3. Time of Death 2259 hrs							
Talloui Examino	4a. Facility Name (if not institution, give street and number) University Hospital	4c. County of Death N/A							
Funeral Director	5. Social Security Number 212 86 7175 6. Sex 7. Age (In yrs. last birthday)	9. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland							
the Maryland a or 28a-f show any tiffed at once. Director	Usual Residence of Decedent  10a. State 10b. County Maryland Anne Arundel  10c. City, Town or Loca Balti  10e. Street and Number	10d. Inside City Limits 1 Yes 2 X No  10g. Citizen of What Country?							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "matural", or items 23a or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 X Married Armed Forces?	U.S.A.  Decify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.							
nours after des Astural", or i Astural", or i Astural and September 2000 Full Bed by Full	1 Yes 2 No 2 N								
5-0036 led within 72 hours aft tygene. other than "natural" the Medical Examine Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 12 We1d  17. Father's Name (First, Middle, Last)	Welding  (First, Middle, Maiden Surname)							
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica To Be Comple	John Thomas Hickle Alice Taylor  19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
ore, MD es 1 and 2 sho of Health and If item 27 is ther traumat	20a, Method of Disposition 20b. Place of Dispo	Walton Avenue sition (Name of cometery, ther place) 1 Cemetery 8/2	Baltimore, Maryland 21225  Date   20c. Location - City or Town, State   29/2012   Baltimore, Maryland						
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	Cedar Hill Cemetery 8/29/2012 Baltimore, Maryland  Once uneral ervice,  22. Name and Address of Facility  Once uneral ervice,  4001 Ritchie Highway Baltimore, Maryland 2122								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that of ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries  Approximate Interval Between Onset and Death								
ed nsit <b>Examiner</b>	Sequentially list conditions, b.								
execut an and al - tra	d amended amended								
), Box 68760, the death certificate be execut by the attending physician and ched for use as the burial - tra Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown								
i, P.O. Beires that the de signed by the lbe detached find by the detached find by Phy	1 Yes 2 ✓ No 3 Probably 4 Unknown								
Records, The law requires ficate has been sig , page 2 should be Completed			24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No						
of Vital Physician: ter this certi eral director	25. Was case referred to medical examiner?  1  Yes 2 No  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred								
Division C Division C To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun ledical Certification.	Aug 24, 2012 2206 hrs 1 Yes 2 No vehicle  Accident 3 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify) Local Street  Aug 24, 2012 2206 hrs 1 Yes 2 No vehicle  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 900 E Patapsco Ave and St Victor St, Baltimore, MD								
To the Hosp within 24 hos To the Fune completely fi		urred at the time, date and place, and atton, in my opinion, death occurred 29c. License number	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)						
	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (them 23a)	O.C.M.E.	August 25, 2012						
40	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore	e, MD 21223						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ()2 Physician/ 1:10P M Donald 2012 Medical Baltimore (if not institution, give street and number) a. Facility Name 4b. City, Town, or Location of Death **Examiner** Chantilla Road atonsville 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 91 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director Baltimore Catonsville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Examiner must be Funeral items 23a Chantilla Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black "natural", Specify: Completed 3 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore City permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Schools leacher 12th arade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 11nnie James Jackson Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2144 Chantilla Koad Catonsville MD 12228 Grace Anna Hines WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Raltimore MD 2/229 29/2012 Donation 5 C Other (Specify) Loudon Park 22. Name and Address of Facility Vaughn C. Green & Funeral Senice 21. Signature of Funeral Service Licenses Randalistown MD 21133 Roda isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the c shock, or heart fai Immediate Causa (Final disease or condition Physician/ resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Division of Vital Records, P.O. Box 68760 🖋 Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pagr 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death

1 Natural
2 Accident 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ature a d title of certifier 29d. Date signed (Month, Day, Year) 8514000

Registrar
DHMH 17 Rev 7/2009

State

\$4105, Baltines

21204

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perfit, G930, 8/29/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Harris 00:38 AM au de tte 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultinge Johns Hopkins If Under 1 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Months Hours (Month, Day, Year) Country) 58 Director 577-74-8930 1 M 2 XF 29 1954 Washington, DC lune Item 27 ie merked other then "neturel", or Iteme 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2K No Reisterstown Baltimore 10e. Street and Number Sesame 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21136 6 Sesamy Ct; Apt 1C 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 😾 No Specify: 3 🗌 Widowed 4 😡 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) cosmetology cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pege 1 and 2 should be file Department of Health end Mental I-Important: If Item 27 Ie merked of any finjury or other treumetic ever prose. ည Fredreatha Hunter George Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1093 Scranton St; Aurora, CO 80011 19a. Informant's Name/Relationship (Type, Print) Charles Hale - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State 8/29/2012 Baltimore, Md On-Site Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Frysician/ SUPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): weeks Examiner preumonia Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ဥပ almonyny years To the Funerel Director: After this certificate has been signed by the attending physiclen and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit obstructive Chronic that initiated events Hospital or Attending Physicien: The law requires that the death certificate be executed hours efter death.
 Punerel Director: After this certificate has been also been also been also. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the F only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Capplei 2012 RES-000 ann August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $Q_{i}$ 1800 N. Urleanst. Baltimore MD 21287 Cappelli aura 31. Date filed (Month, AUG 29 32. Regisfrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Eileen 2012 6:00 Рм Marv Hiser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3422 Northway Drive Parkville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Days (Month, Day, Year) 1 M 2 T F Hours 89 Director 219-14-5162 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Maryland **Baltimore** Parkville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21234 3422 Northway Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 X Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Underwriter Insurance Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse B. Hiser Jessie P. Vanorsdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Parkville, Maryland 21234 Francisco - Sister 3422 Northway Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 08-28-2012 Towson, MD 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Future I Service Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List party one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Demen Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Artery Completed 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si al director, page 2 should l Heart 24b. Were autopsy findings available prior to completion of cause of death? Consistive 24a, Was an autopsy performed' Sick Sinus 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Other: 4 Nursing Home 5 AResidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COI N Carolina ST 17/42

MD

Ashar

32. Registrar's Signature

29c. License number

00053955

Britimore MD 21287

29d. Date signed (Month, Day, Year)

August 27, 2012

State of Maryland / Department of Health and Mental Hygien

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JOHN 28 AM AUGUST 2012 0200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 4900 Fait Avenue If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Jan. 13,1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. 89 215-14-0541 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral', or Itams 23a or 28e-f show Examiner must be notified at 1X Yes 2 No Baltimore City MD N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4900 Fait Avenue United States 21224 filed within 72 hours after death. Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White "natural', ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Compl College (1-4or 5+) Elementary/Secondary (0-12) Western Electric 10 Years Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Pfaff John F. Hahn, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4900 Fait Avenue Baltimore, Maryland 21224 (Wife) Mrs. Ruth S. Hahn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
14☐Burial 2☐Cremation 3☐Removal from State 8/31/2012 Baltimore, Maryland Oak Lawn Cemetery \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Septico Licensee Michael Neiser 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a DEMENTIA 10 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to for as a consequence of) Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) the à signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Tyes Completed HYPERTENSION, CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an AORTIC ANEURYSM has e 2 autopsy 2 200 certificate 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 💢 No Certification: To this After this funeral o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 - Homicide 24 hours a a Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To tha ! 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D6203Z AUGUST Z8 2012 30. Name and ddress person who completed truse of death (Item 23a) (Type, Print) 5505 HOPKINS BAYVIEW CIRCLE JENNIFER HAYASHI BALTO.MD 21224 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARUE MOSES Month HALL 23 3 Day 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death E. Thornhill Place FREDERICA PLEDERICK 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 240-20-0812 1 M 2 D F **Director** 90 DEC. 25,1921 NORTH CAROUN 28a-f show 10a. State filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director MD FREDERICK FREDERICK 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be n Funeral 21701 1092 THORNHILL PLACE USA "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) SERVICE WAL- MART PROVIDER 340 other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ٩ permit. Page 1 and 2 should be Department of Health and Mente. Important: If item 27 is marked any injury or other CHARUE HALL SR GMMA (UNK) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE HALL 1092 6. Thornhill Place FREDERICK MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 31, 2012 SM MISBURG 4 Donation 5 Other (Specify) SMITHSBURG CREM. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FUNCAL HOME saula. Rolle TREOBRICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronny Artiery Physician) ATHERO Sclerusis disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a sunsequence of, attending physician and I for use as the burial-transi Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 ☐ Yes 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Dear 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State! within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of

certifie

Toll House Ave. Frederick, MD 21701 KAZMI. 814 MB **AUG 29** 

Name and address of person who completed cause of death (Item 23a) (Type, Print)

4795

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:30 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Linthicum ANNEARUNDE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Month, 1 M 2 F 69 Yrs. Months Hours Min WAShingTON D.C **Director** 28a-f shov 10a. State 10b. County Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City **Funeral Director** be notified 1 ☐ Yes 2 ☑ No ADISA 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code 23a items 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once, Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or BOYD MD.21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) DE CREMATION 8-28-12 OPENTION MID! LANEATY FUNERAL HOME Signature 12601 MOUNTHIN RO. PASADEAM multications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or conshock, or hear failure. List only Immediate Cause (Final astic ndron Ph\_sician/ Non disease or condition Medical resulting in death) r as a consequer ce Examiner e Sequentially list conditions, in any, reading to minimum action cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Day Month Pregnant at time of death 5 Other (specify) signed by the a Yes No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an s certificate has be director, page 2 s autopsy 1 🗆 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOUS Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) Certificate: Manner of De fi 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🗀 No 28d. Describe how injury occurred After injury 5 Pending Natural n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident Investigation Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

HSh

DHMH 17 Rev 7/2009

State

Registrar

HOSPI

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 2 9 2012

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 August 2012 9:00am Sam Edward Hall, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 222 Edmund Street Aberdeen Social Security Number Funeral 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 237-52-3284 76 0271071936 North Carolina Director 1**₹** M 2 □ F or than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours efter death with the Maryland end Mental Hyglene. Is marked other than "naturel", or items 23a or 28a-f sho 10b Count 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Harford Maryland Aberdeen 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 222 Edmund Street 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

12 Yes 2 No
If Yes, Give 1952-Black White etc. δ 1 Never Married 2XXMarried Maryland 21215-0036 1 Yes 2 No Specify: 1975 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed Elementary/Secondary (0-12) College (1-4 or 5+) US Government Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Henry Walter Hall Clara Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 John Hall (son) Ragan Road, Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Page 1 Department of Nation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 8/31/2012 Bel Air, Maryland 21. Signature of Funeral Service A 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Funeral Director: After this cartificate has been considered by the transfer of the constitution of t Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown complication 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 CHIAZIC 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 Vo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural
2 Accident
3 Suicide 5 Pending injury Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Certifying Number Practitioner To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Harre de boun 2027 Ma31078

Registrar

31. Date filed (Month, Day, Year)

2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 Marjorie A. Hobbs 11:19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9312 Fitzlanding Lane Owings Mills Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min (Month Day Year 8-23-1931 Country) Barbados 119-42-5402 1 □ M 2 🗓 F **Director** 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No M Baltimore Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funera 9312 Fitzlanding Lane 21117 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 X Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify. Black If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dental Techinician Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edith Miller permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia Hobbs/Daughter 9507 Oak Trace Way, Randallstown, MD 21133 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State Roschill Memorial Park 9-1-2012 New York 4  $\square$  Donation 5  $\square$  Other (Specify) Wylie Runeral Rome P.A. of Paltimore Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9200 Liberty Rd., Randallstown, MD 21133 23a Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURG disease or condition resulting in death) Medical Examiner inherma Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Due to or is a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death the a 1 ☐ Yes 2 ≥ 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 2 🗌 No 1 Yes Yes filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work?
1 Yes 2 No Natural Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

enves

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

08-23

3 🗵 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

HECKSTALL WANDA Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	State of	Marylan		irtment of tificate of			lental Hy	giene Reg. No. 2	012	27615
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Examin		4a. Facility Name (if not institution G000 SAM PRIT				4b. City, Town, BALT[/			)	4c. Cour	ity of Death	
Funeral Director		5. Social Security Number 219-84-0001 Usual Residence of Decedent		Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Unde	er 24 Hrs.	8. Date of Bir (Month, Da 10/27	ıy, Year)	9. Birthp Count MD	olace (State or Foreign try)
aryland e-f show fied at	ctor	10a. State 10b. County N/A			,Town or Loc				·	-	1	0d. Inside City Limits 1 🏖 Yes 2 □ No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	ģ	11. Marital Status 1 ☐ Never Married 2 ☐∰Marr 3 ☐ Widowed 4 ☐ Divorced	16 1/ (2)	es? ☑ No	If	/as Decedent of Yes, specify Cub	oan, Mexica	an, Puerto I		BI	ace - America ack, White, e fric Ame	atc. an
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t. Page 1 e tment of H tant: if ite ijury or ott		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	pecify)	ate Oa.	klawn	ition (Name of atory or other pla Ce <b>m</b>		9/5/		20c. Location Balt.,	MD	
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		30. Name and address of person v NUTAN, GOOD SA	MARITAN 1	LOSPING	H, LOCA	int) H RAVO	-	3LVI	, BAL	TIMOR	E, MI	D.
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Registrar

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death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar				tificate					Reg. No.2	012	27	617
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vaa John Johnson Medical 2012 August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Senior Living Ellicott City Howard 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Ye **Funeral** If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours Min. Director Vre 170-26-4322 82 1929 11-14 Greece Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No |Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 3100 North Ridge Road 21043 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 1 No Specify: Specify.White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Allegheny Ludlum Chemical Engineer permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 injury or other traumatic John Johnson Papacostas Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra Watrous/daughter Morningview Ave Akron, OH 44305 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hope Cemetery 8/31/2012 Pittsburgh, PA 4 Donation 5 Other (Specify) Signature Funera S rvice Link nsee 22. Name and Address of Facility Craig Witzke Funeral Care any Moo751 Newburg Ave Catonsville MD 21228 23a. Part 1. Enter the disease, or demplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ men disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the bunial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year ☐ Pregnant at time of death ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director: After this certificate I filled in by the funeral director, pag 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Hospital Other: 1 Yes Assited Livy 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examinem On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) 2012 rson who completed cause of death (Item 23a) (Type, Print) C1785 LOW M 334 edan

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State

Registrar

31. Date filed (Mo) th,

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Physici Medical Exami		Decedent's Name (First, Middle,Last)	n Denise K	 Litchen	2. Date of De Month August 2		3. Time of Death 2251 hrs
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death with or items 23	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X N	If Yes	Decedent of Hispanic Orig s, specify Cuban, Mexican,		White, etc.	erican Indian, Black,
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho- matte event, the <u>Medical Examiner</u> must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mos	st of working life. DO NOT		Hospital	•
21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than is event, the Medical	Be Cor	17. Father's Name (First, Middle, Last) Ralph L. Kit	chen	18.Mother	s Name (First, Middle, Sharon A.		
D 21 should bend Mer is mar	2	19a. Informant's Name/Relationship (Type, Print) Sundae Ann Warner / Daughte		Address (Street and Num reenhaven La			
- P = 8 8		20a. Method of Disposition	0b. Place of Dispositi	on (Name of cemetery,	ne C1	rcleville,	
MOF Pages 1 ent of 1 r other		1 Burial 2 Cremation 3 Removal from State Bonation 5 Other Specify:	crematory or othe Bayview Cr		08/27/201	2 Baltimor	e, Maryland
Baltimore, permit. Pages 1 at Department of He Important: If ite		21. Signal of Funeral Service Leef Lee		me and Address of Facility			
Physician Medical	) ) ()	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.		)1 Ritchie Hi mode of dying, such as ca			ryland 2122  Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	iğ.	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time o	2 Feta	I death 3 Ectopic	pregnancy	Month	Day Year
). BC t the deg by the g	Physic	Part II. Other significant conditions contributing to death but n	ot resulting in the un-	derlying cause given in Par	t I. 23e. Did	tobacco use contribute t	o the cause of death?
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		Suicide Could not be determined (Specify) Local St	treet	factory, office building, etc	or Town, 900 E. Patap	State) sco Ave & St. Victor	
Di To the Hospital within 24 hours To the Funeral	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	-			` '	
F. ≥ 5 8	Me	29b-Signature and title of certifier	A	29c. License number		29d. Date signed (M	
T.1	-	30. Name and address of person who completed cause of death (I	tem 23a)	O.C.M.E.		August 25, 2012	<u>-</u>

Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) AUG 2 9 2012 State Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf g931 9-10-12 yt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	PI	hysicia	n/	1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	ath D	av Yea	ar	3. Time of Death	
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	}	Examin	er		Stella Maris Hospice				or Locatio	n of Death		4	c. County of D Balt		ro	
	Fu	uneral		5. Social Security Number		. Age (In yrs. Is	ast birthday)	If Under 1 Year	If Und	er 24 Hrs.	8. Date of Bir	th	9.	Birthpla	ce (State or Foreig	n
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	p	at at	١	Usual Residence of Decedent  10a, State 10b, Count	v		y, Town or Lo	cation			11/00/	193	0 /		land I. Inside City Limits	
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	the M	or 28 e noti		MD Bal Bal 10e. Street and Number	rmore	] th	otting	10f. Zip Code				10g. C	Citizen of What	Country	/?	_
	with	s 23a ust b	Funeral	7827 Perry Ro	ad			21236				1	U.S.A.			
	death	item: ner m		11. Marital Status	12. Was Deced Armed Ford		S. 13. \	Vas Decedent of f Yes, specify Cub	Hispanic (	Origin? (Spe	cify Yes or No- Rican, etc.)		14. Race - A Black, W			
р.ш.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al", or xami	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give		- 1	☐ Yes 2 🛣 N					Specify:			
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		J.,		23a. Part 1. Enter the disease, shock, or heart failure. List			h. Do not ente	er the mode of dyi	ing, such	as cardiac o	r respiratory ar	rest,		lr.	pproximate nterval Between	
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Division	Atte er de	by th	Certificate:	3 Suicide 6 Coul 4 Homicide deter	mined 28e. Place o	f Injury - At ho		eet, factory, office			28f. Location (S			Rural Ro	oute Number,	
<u>5</u>	ital or	ral Dii lled in			Dallanis	,, etc. (opec.,)					City of You	rri, Otal	e)			d
	To the Hospital or Attending Physician: The law within 24 hours after death,	Fune stely fi	Medical	(Check 2 Medical	g Physician: To the bes Examiner: On the basis	of examination	n and/or invest	igation, in my opir	ion, death	occurred at	the time, date a	and plac	e, and due to the	he cause	e(s) and manner stat	ed.
	o the	o the	Σ	only one) 3 X Certifyii 29b. Signature and title of certifi	g Nurse Practitioner:	To the best of n	ny knowledge,	death occurred at			ice, and due to t		se(s) and manne ate signed (Mo			_
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				30. Name and address of person	who completed cause	of death (Item	23a) (Type, F	rint)					010			
				TRACIE L. MO	450 AM A A A A A			Y VALLEY	RD.	TIMO	ONIUM,	MD 2	21093			
	R	Stat egistra		31. Date filed (Month, Day, Year)		ictrar's Signat	ture	.4.1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Lol 2 4:50 p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Columbia Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Director 218-28-6676 1**X** M 2 □ F Yrs. 11-27-1931 MD show it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3306 N. Hilton Street, Apt 203 Page 1 and 2 should be filed within 72 hours after death with 21216 USA Was Decedent Armed Forces? Yes 2 X No 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify. 3 Widowed 4 Divorced SpecifyAfrican-American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Printer The Mille Centre Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernard H. Lee Alice Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall Carroll/ Guardian 3308 N. Hilton Street, Apt. 303, Baltimore, MD 21216 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. injury or 8-28-2012 Pikesville, MD Druid Ridge Cemetery Signature of Funeral Service Licen 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 232 Part 1. Enter the disease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sequence of): Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician sthe burial or Attending Physician; The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 D Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has page 2 performed? death? Yes 2 W Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital မှ 1 🗌 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending the 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1010 Kol. 32. Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #1, FER MD G93 1 9.20.12 TRT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 201 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN GILBERT LOPES 11:30AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD COUNTY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1**X** M 2 □ F Davs 5/6/1937 Country) 575-36-2035 **Director** HI Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Honolulu Kailua 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1410 Ulupii St. 96734 USA Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 1955-59 Specify: Portugese 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) ith and Mental Hygien 27 is marked other the r traumatic event, the Elevator Mechanic Otis Elevator Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ John F. Lopes Esther Amorin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Lopes/Wife 1410 Ulupii St., Kailua, HI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Department of Important: If any injury of once. Carroll Crematory 8/28/2012 4 Donation 5 Other (Specify) Winfield, MD Signature of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, P.A. ani 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of **Examiner** Pheumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician a detached for use as the burial-Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year 1 Yes 2 1 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? this certificate has ral director, page 2 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director pane 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Department 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Myrw ly MD D0064760 Aug, 28, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYTHILY VANCHA, 11085 Little Paturent PKWY, Swite LOOI, Columbia 31. Date filed (Months Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19 state of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August BARBARA 2012 8:30 LICHTER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) **Director** 213-40-1143 1 🗆 M 2 🛛 F 70 11/29/1941 Usual Residence of Deceder MD oe filed within removes ental Hygiene.
Inked other than "natural", or Items 23a or 28a-1 snow.
Ite ovent, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7111 PARK HEIGHTS AVENUE, #214 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-!f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 Ã No Specify: Specify: WHITE Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DIRECTOR CEMETERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of ၉ ALBERT MOSS EDITH LEVINE 19a. Informant's Name/Relationship (Type, Print)
Lichter
SAMUEL LICTHER/HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Departmant of Heath ar Important: If Item 27 is any Injury or other trau 7111 PARK HEIGHTS AVENUE, #214, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/26/2012 BALTIMORE, MD 21. Signature Funeral Service Lices 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Metastatic Small cell Lung disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Exami or Attending Physicien: The law requiras that the deeth cartificate ba executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending physical for use as the b IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Completed To the Hospital or Attending Physicien: The law requirar within 24 hours after death.

To the Funeral Director: After this certificate has baen siy completely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💆 No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D70334 Agenst

DHMH 17 Rev 06-2011

State Registrar Salisbury, MD 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lijuh Zhou PoBox 2613, Sa

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death lauz Physician/ Month 429051 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 40PKINS Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 092-50-8683 1 ☑ M 2 ☐ F 54 October 26, 1957 New York 2 should be filad within 72 hours efter deeth with the Meryland ith end Mentai Hygiene.
27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, it e Medical Exertine that the notified et 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 😾 No <u>Maryland</u> Calvert Huntingtown 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 4380 Dunn Road 20639 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ☑ Yes 2 ☐ No 1976 — Yes, Give Black, White, etc. ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 Widowed 4 Divorced Completed Specify. White 1980 Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Psychotherapist Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Kenneth Mauzy Agnes Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 sh Depertment of Heeith er Importent: If Item 27 is eny injury or other tret Charlotte Mauzy/Wife 4380 Dunn Road, Huntingtown, Maryland 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, West Arundel Cemetery 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 31, 2012 Odenton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 M01386 د Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-ease on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se psis Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner versus-host disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physicien end s the buriei-trensit To the Moepitel or Attanding Physician: The lew requires that the deeth certificete be axecute within 24 hours after death.

To the Funerel Director: After this certificete hes baen signad by the attending physicien and completely filled in by the funerel director, page 2 should ba deteched for use es the buriel-trem that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N Orleans St. Baltimore MD 21287 DANIEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Michael	William	Molnar	
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viichael vviiilam iv		State of Maryland / Department of Health and Mental Hyglene  Certificate of Death  Reg. No. 20   2   6	2762
Physician	1/	1. Decedent's Name (First, Middle, Last)  A TOLLA FILL TAM MOLINA D  A STIME	of Death
Redical Examine		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  9522 Hallhurst Road  4c. County of Death  Baltimore County	J 1113
Funeral Director		5. Social Security Number 219-31-5316 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 8. Days 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 8. Days 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Number 219-31-5316 7. Age (In yrs. last birthday) 9. Birthplace (Security Num	
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the Mar	Director	9522 Hallhurst Rd. 21236 USA	
more, MD 21215-0036  Pages I and 2 should be filled within 72 hours after death with the Maryland not of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", ur items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once.	by runeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American India White, etc. 17. Yes XX No 18. Race - American India White, etc. 18. Page 19. White	in, Black,
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21215-0036 Uld be filed within 7 Mental Hygiene. Marked other than r event, the Medica	200	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Diana Lynn DeGraw	
MD 21 d 2 should lith and Me m 27 is man numatic cv	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod  2231 Firethorn Rd. Baltimore, Md. 21220	e)
Baltimore, Normit. Pages I and Department of Health Important: If item:		20a. Method of Disposition  1 Burial 2XXX Cremation 3 Removal from State Petro Crematory, Inc.  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other Specify:  20c. Location - City or Town, State Petro Crematory, Inc.  8-30-2012 Baltimore, Md	
Baltimo permit. Page Department of Impurtant:	1	22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236	6
Physician Medical Examiner		failure. List only one cause on each line.    Betwe	ximate Interval een Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
60,  the be executed hysician and e burial - transit		if any, leading to immediate  cause. Enter Underlying Cause (Disease or injury that initiated	
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50, te be ex hysician e burial		■ MENDED 23a,pt.II,27,28a-f,per me,g931 9-6-12 sm  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
be death certificate be executed to the attending physician and check for use as the burial - transit	y siciality	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
P.O. Es that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause  1 Yes 2 No 3 Probably 4	
of Vital Records, P.O. Box 68760,  1g Physician: The law requires that the death certificate be executed  1. The law requires that the death certificate be executed  1. The law cornificate has been signed by the attending physician and  1. The Recompleted by Dhysician Medical Expension	numberen	24a. Was an autopsy find prior to completion death?  1 ✓ Yes 2 No 1 ✓ Yes	
Vital Revysician: The his certificate director, page		25. Was case referred to medical examiner?  Hospital: Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene	
ion of Vi tending Phys cath. tor: After this the funeral di	: h	1 ✓ Yes 2 No No Notice 2 ER/Outpatient 3 DOA Oute 4 Nursing Home 5 Residence 6 ✓ Other: Scene  27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Selection of Injury (Month, Day, Yeer) Fd 8-26-12 Fd 08:00 am	
Division of spital or Attending spital or Attending tours after death.  filled in by the function:		28e. Place of Injury - At home, farm, street, factory, office building, etc.  Suicide Homicide  Could not be determined  Specify)  Single Family Home  28f. Location (Street and Number or Rural Route or Town, State) 9522 Hallhurst Perry Hall, MD.	Number, City
To the Hosp within 24 ho To the Func completely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	;)
		29b. Signature and title of certifier  29c. License number  O.C.M.E.  August 27, 2012	(ear)
	-	30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Stat Registra	е	31. Date filed (Mocky Year) AUG 2 9 2012  32. Figistras's Signature	
DHMH 17 Rev 1/200		ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar 27626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Louise Mullenax 2<sup>1</sup>5, 2012 August 1:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 206 Baltimore Annapolis Boulevard Severna Park Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth Hours 215-22-7729 Director 1 □ M 2 🗓 F 88 04-02-1924 West Virginia Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Mant if item 27 is marked of other than "natural", or items 23a or 28a-1 show ury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at must be notified at 10c. City. Town or Location Completed by Funeral Director 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Baltimore Annapolis Boulevard 21146 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lee Huffman Susan Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 Sheila J. Croft - daughter 204 Baltimore Annapolis Blvd., Severna Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem Park | 08-30-2012 | Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Sign 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician or use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent precurant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death Month Day Year signed by the and be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use gontribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 1 No Other: ျှ 1 Y95 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) er of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending

Box 68760 Division of Vital Records, P.O. Hospital or Attending Physician: death. after 24 hours a

work? M 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

Director:

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		epartment of Health and	Mental Hygi	ene	07607
			Registrar  1. Decedent's Name (First, Middle, Las		Certificate of Death		g. No.2012	61061
	Physicia Medic			MENSAH		2. Date of Death Month	Day Year	3. Time of Death 05:51 AM
#	Examin	er	4a. Facility Name (if not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
-	Funeral		GOOD SAMARITAN  5. Social Security Number 6. S		BALTIMORE,  av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreign
	Director		0001	M 2 □ F 73 Yrs	Months Days Hours Min.	(Month, Day, )	(ear) Cour	
	rland f shov	tor	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mary 28a-1 otifie	Director	MD	BALT				1 X Yes 2 □ No
	ith the 3a or t be r	ral	10e. Street and Number	AVENUE	10f. Zip Code 2/2/14	10	0g. Citizen of What Coul	ntry?
	ems 2	Funeral	2404 PINEWO	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	ean Indian
တ္က	fter de , or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🏲 No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 Mo Specify:	Rican, etc.)	Black, White,	etc.
Ö	ours a rtural' al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Specify: BLA	rck
7	n "na nn "na Medio	Completed	15. Decedent's E (Specify only highest gra	ade completed) (G	ecedent's Usual Occupation rive kind of work done during most of wor e. DO NOT use retired)	king 1	6b. Kind of Business/In	dustry
21215-0036	within giene. er tha , the I		Elementary/Secondary (0-12)	College (1-4 or 5+)	ACCOUNTANT	4	SINAI HOS	PITAL
pu	be filed within 72 hours after death with the Maryland and Hygiene. Red other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	,	
Maryland	should be file and Mental I is marked o raumatic eve	-	Ernest Noah	Dist.		ENSIWA		
<u>⊠</u>	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Heath and Mental Hygiene. ordant: I filem 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at e.e.		19a. Informant's Name/Relationship (T)  GRACE M. MENS		lailing Address (Street and Number or Rui 04 Pine Wood Ave			
re,	1 and of Hea item other		20a. Method of Disposition	20b. Place of Di	sposition (Name of	Date 2	Oc. Location - City or To	own. State
<u>m</u>	Page 1 ment of ant: If it ury or o		1 <b>Z</b> <sup>2</sup> Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specit</i>	Removal from State Morely, 6	AND CEMETERY 9/1 22. Name and Address of Facility VA	4/12	BALTIMORE	e, Md
Baltimore,	permit. Page Department Important: I any Injury o once.		21. Sign of re of Funeral So vice Licens	00	22. Name and Address of Facility VA	UGHN GR	EENE FUNE	RAL SCUS
	TB= 60	- "	23a Part 1 Enter the disease or com	olications that caused the death. Do not	4905 York RoAl			
	hysician/		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	, ,	or respiratory arres	,	Approximate Interval Between Onset and Death
1	Medical		disease or condition resulting in death)	a. SEPTIC SHOCK  Due to (or as a consequence of):			-	
	Examiner		Sequentially list conditions,	ASPIRATION PN	JEUMONIA			
7	sit a	Examiner	cause. Enter Underlying	Due to (or as a consequence or).				
W.	be executed sician and burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. HYPOGICEMI,  Due to (or as a consequence of):	H			
09	s be ey /sician e buria	dical		d				
876	uncate ng phy e as th	Med	IF FEMALE:					
9 X	tn cen ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death			23d. Date of deliver	*
P.O. Box 687	r the a	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month	Day Year
P.O	rnar rr ned by e deta			ontributing to death but not resulting in the		23e. Did toba	acco use contribute to the	ne cause of death?
ds,	quires en sig ould b	Completed by		DIABETES MELLI	,	1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
Division of Vital Records,	law rei nas be e 2 sh	nple	RENAL DISEASE,	CONGESTIVE HEAR	T FAILURE	24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
g F	icate l					Yes 2	ed? death?	2 <b>N</b> o
Ital	sician certif irecto	00	25. Was case referred to medical examiner?  1 ✓ Yes 2 □ No	Hospital:	26. Place of Death (Chec			
ot \	g rny erthis neral c	e: To	27. Manner of Death	1 Inpatient 2 ER/Outpa 28a. Date of injury 28b. Time	e of 28c. Injury at	ome 5 L Residen 28d. Describe how	ce 6 Other (Specify injury occurred	)
ou	endin sath. or: Aft. the fur	ficat	1 Natural 5 Pending 2 Accident Investigation		y work? M 1 ☐ Yes 2 ☐ No			
VISI	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
בֿ בֿ	ours a		29a, Certifier 1 Certifying Phys	ician: To the best of my knowledge, dea	th occurred at the time, date and place a	and due to the cause	e(c) and manner as stat	ed.
3	To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exami	ner: On the basis of examination and/or in e Practitioner: To the best of my knowled	vestigation, in my opinion, death occurred a	t the time, date and	place, and due to the car	use(s) and manner stated.
_ 5	vithi To th		29b. Signature and title of certifier		29c. License number		d. Date signed (Month,	Day, Year)
			Alshours	M.D.	RES 000		8/26/201.	2
	5		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type	e, Print) RAVEN BOULEVAR!	RAITIA	1 /	
	Stat	e_	31. Date filed (Month, Day, Year)	32. Jegist er's Signature.	7.4	, DHLIII	ival, in	W/W07
	Registra	ır	AUG 2 9 20	172 Sur B. 4	pare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8 Month 23 Day2012 Year 1:45 P Derreck Kevin McConnell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 578-86-8498 1 X M 2 □ F Director 10/25/1960 Virginia 51 Yrs. 10b. County 10c. City, Town or Location r then "natural", or items 23e or 28a-f sho 10d. Inside City Limits Director MD Prince George's Temple Hills 1XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4106 Norcross Street 20748 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married ģ Connell, Derreck If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: 3 Divorced 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 years Hygiene. Elementary/Secondary (0-12) Disabled | permit. Pege 1 end 2 should be filed with Depertment of Health and Mental Hygier Important: If Item 27 is marked other to any Injury or other treumatic event, the Once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert McConnell Evelyn Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn McConnell/Mother 4106 Norcross Street Temple Hills, MD 20748 Baltimore, 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 8/29/2012 Cedar Hill Cemetery Suitland, MD Signature of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home Trurt 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ardiopu lmonary Medical resulting in death) Examiner static Sequentially list conditions, Je J if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir after death.

Director: After this certificate has been signed by the attending physicien and d in by the funeral director, page 2 should be detached for use es the buriel-transit or Attending Physicien: The lew requires thet the death certificete be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Compression ara 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certificate: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending înjury 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospitel o within 24 hours af To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 074374 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville md 20850 9901 Medical Ctr Dr Kommineni MD aya 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Dav Joan S. Norwitz 2012 8 1:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 701 Fallsgrove #208 Road Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 1 F Days Hours Min (Month Day Year) 8-17-1939 Washington, DC Director 578-56-5772 Usual Residence of Decedent or 28a-f shov 10a. State 10b, County Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 X Yes 2 ☐ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #208 20852 United States 701 Fallsgrove 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋No Specify: Specify. Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. 4 Retail Human Resource Associate Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Saltzstein Lewis Sycle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852701 Fallsgrove Road, #208, Rockville, Maryland Martin Norwitz - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State King David Mem. Park : 8-29-2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sage1 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Uterine Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed' 2 No Yes 2X No 1 \sum Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗆 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064983 8-28-2012

Registrar
DHMH 17 Rev 7/2009

State

2101 Medical Park Drive, #200, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Red

Kashif Firozvi, MD

**AUG 29** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 2012 SHARON LYNN NEVE 1:20 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3705 SINGER STREET HAMPSTEAD CARROLL Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min **Director** 213-68-4661 1 □ M 2 🛣 F 8/21/1955 MARYLAND 56 or 28a-f shov should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CARROLL HAMPSTEAD 1 🗌 Yes 2 ី No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 3705 SINGER STREET USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 - Widowed 4 X Divorced Year or Dates 1973-1981 WHITE 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE MANAGER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ERMA HARLFINGER WILLIAM KUSZMAUL, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KRISTIE A. WITTE/DAUGHTER 3705 SINGER STREET HAMPSTEAD, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 🗆 Cremation 3 🗀 Removal from State GARRISON FOREST PVA 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2012 CEMETERY OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO027 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Noncompliance with 1 

Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Hy pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Hyperlipidemia 2 🗌 No 1 Yes 25. Was case referre to medical examiner? the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 1 5 Pending injury 2 Accident
3 Suicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined 24 hours 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 00035363

DHMH 17 Rev 06-2011

Registrar

Sandra

31. Date filed (Month, Day, Year)

10

BVAMC

Green Street

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

z-00529 itephen R Ors:	zula	State of Maryland / Depart	tment of Health and Mental					
		4	ficate of Death	7.5	2012 2763			
Physic	ian/	Decedent's Name (First, Middle,Last)		Reg. No.	3. Time of Death			
nedical Exam	ine	beephen kichard orszura		Month Day August 22, 2012	2 Year 0758 hrs			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		County of Death			
	ŕ	Baltimore Washington Medical Center	Glen Burnie		nne Arundel			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24H Months Days Hours M		DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)			
		247-17-9051   1X M 2 F   38	Yrs.	January 30	,19/4 Country) - 7			
any			own or Location		10d. Inside City Limits			
	_	Maryland Anne Arundel	Millersville		1 Yes 2 X No			
Aaryland 28a-f show i at once	Director	10e. Street and Number	10f. Zip Code	10g. Citiz	en of What Country?			
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiers, and mental Hygiers in the 23 or 28s-f sho mit. If them 27 is marked other than "natural", or items 23a, or 28s-f sho in other traumatic event, the Medical Examiner must be notified at once		1764 Baldwin Drive	21108		United States			
n with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 V Naver Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian, Black,			
r deatl or ite	Fun	1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.			
s after ral", nioer	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: White			
2 hour "nate	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Sa. Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re		nd of Business/Industry			
36 thin 7, than than	ple		Automobile Mechan	ic	Automotive			
5-00 ed wil lygien other	Completed	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden S				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Swietobor J. Orszula	Joan M	arie Walker				
D 21 hould nd Me is ma	٦		19b. Mailing Address (Street and Number of	Rural Route Number, City	y or Town, State, Zip Code)			
MD and 2 sho alth and sm 27 is	Ш	Swietobor J. Orszula/Father  20a. Method of Disposition	1764 Baldwin Drive,					
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite			ce of Disposition (Name of cemetery, matory or other place) Arundel Au	Date 27,	ocation - City or Town, State			
ti Pag tment rtant:		4 Donation 5 Other Specify: Crem	atory	2012  Od	enton, Maryland			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after permet. Pages I and Amendal Hygiera. Important: Witem 77 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Ш	21. Signature of Funeral Service Licens  MO0672	22. Name and Address of Facility Donaldson Funeral 1411 Annapolis Ro	Home & Crem	atory, P.A.			
Physician	5 11		1411 Annapolis Ro	ad, Odenton,	Maryland 21113 k, or heart   Approximate Interval			
/Medical		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. <b>Mixed drug</b>	hydromorphone, oxycod	one and Prom	nethazine Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Intoxication  Due to (or as a consequence of):			Dean			
	_	Sequentially list conditions, b						
	Examiner	if any leading to immediate Due to (or es a consequence of):						
A	хап	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
executed an and al - transit		d.						
F 8 6 √	an/Medical	x UNPENDED AMENDED 23a, 27, 28a	H G944 10/28/2013 WS	2 sm				
Box 68760, death certificate be he attending physicid for use as the buri	M	IF FEMALE: 23b. Was decedent pregnant in the	су	23d.	Date of delivery			
ox 687 eath certifications attending	icia	past 12 months?	Fetal death 3 Ectopic pregn  5 Other (Specify)	aricy N	Month Day Year			
	Physici	1 Yes 2 No 9 Unknown g Unknown						
ires that the signed by a be detached	P P	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		se contribute to the cause of death?			
S, F quires an sign					No 3 Probably 4 ✔ Unknown			
Cords, law requir has been s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
Rec The licate l	8			performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No			
Vital Reorgician: The his certificate director, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check					
Division of Vital Records, ral or Attending Physician: The law requires after death.  al Director: After this certificate has been seen in the funeral director, page 2 should	리	1 ✓ Yes 2 No		ng Home 5 Residence				
ading th.	Ö	1 Natural 5 Pending (Month, Day, Year)	1 Ves 2 W No	28d. Describe how injury unknown	occurred			
Atter dea	icat	2 Accident Investigation 10 8-22-12 1	farm, street, factory, office building, etc.		Number or Rural Route Number, City			
List after Div	Certification:		ls house	or Town, State) 43 Gambrills, M	O Avrlawn Dr.			
Hosp 24 hor Func		29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	leath occurred at the time, date and place, and					
Division of V To the Bospital or Attending Phy. within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral d	Medical	one)  2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurred	at the time, date and place	e, and due to the cause(s)			
L > F 0	Ž	29b. Signature and title of certifier	29c, License number	29d. Da	te signed (Month, Day, Year)			
		tota Uronia- Tollah-	O.C.M.E.	Augus	st 23, 2012			
d		30. Name and address of person who completed cause of death (Item 23a	,	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
7			miner 900 W. Baltimore Street, E	Saltimore, MD 21223	3			
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ klah 2012 Medical 4a. Facility Name (if not institution, give stre Town, or Location of Death 4c. County of Death **Examiner** Kandallstown altimore Jorthwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 🗆 M 2 🗹 F Months Days 13-60-Yrs. **Director** 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21244 115 H LOGO items death 12 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Completed ac the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N lanotacturin Be 17. Father's Name (First, Middle, Last) မ eorge 01 Infor ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) imore Greene Funeral Services Signature of Funeral Service Licenses 22. Name and Address of Facility MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ theros disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by has been sig ge 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performe death? certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) director Other: 2 🔀 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of D0063918

DHMH 17 Rev 7/2009

Q

State Registrar who completed cause of death (Item 23a) (Type, Print)

Sm

onne Date filed (Month, Day, Year, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 21:34 M AUGUST Dorothy Virginia Plourde 2012 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🔽 F 213-54-1541 85 04 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 149 South Kossuth Street 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🔯 No Specify: Specify: Black 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade <u>Environmental Services</u> <u>St. Agnes Hospital</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Carter Pauline Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 South Loudon Ave, Baltimore, Md 21229 Linda Hawks-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/30/2012 Baltimore, Md Mt. Zion 21. Signature of Fundal Service Lig Markand Address of acility Baltimore, Md 21215 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death PNEUMONIA ASPIRATION DAYS disease or condition resulting in death) Due to (or as a consequence of) NOWTHS LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? tions contributing to death but not resulting in the underlying cause given in Part I. 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

Director

Funera

<u>გ</u>

Completed

Be

ပ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rediffied at once.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed

Examine

Physician/Medical

Completed by

Be (

Certification: To

Medical

has this After t

P.O. Box 68760

Division of Vital Records,

OURDE

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
Part II. Other significant condit

		1 🔁 Yes 2	No 3 Probably 4 Unknow				
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
25. Was case referred to medical	26. Place of Death (	Check only one)					
examiner? 1 ∏ Yes 2 <b>⊠</b> No	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 Residence 6	Other (Specify)				

1 Yes 2 XN	lo
27. Manner of Death	
1 XNatural	5 Pending
2 Accident	investiga
3 Suicide	6 Could no

tion 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

3455 WILKENS AVENUE - SUITE LLO

21227

Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

4 🗌 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D0070917

BALTIMORE, MD

29d. Date signed (Month, Day, Year) AUGUST 27 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BHAVANDEEP BAJAJ

31. Date filed (Month, Day,

State Registrar

DHMH 17 Rev 1/2001

Director:

o 24 hours after e Funeral Direc

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Floice 20 ĬŽ Peele 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3809 Mt. Airy Dr. Mt Airy Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 445-16-5326
Usual Residence of Deceder 1 □ M 2 🛣 F 93 5/7/1919 AR Il Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XXNo MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3809 Mt. Airy Dr. 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 PNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ★ Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Secretary Dept. of Defense 17. Father's Name (First, Middle, Last) should be file and Mental F is marked o 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 end 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Henry Alfonso Moore Amanda Melissa Brumley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Victoria Rusbosin</u> 3809 Mt. Airy Dr., Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 8/29/2012 Washington, DC 21. Signature of Funeral Service Lic <sup>22</sup> Burrier Queen Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death
MINORS ventricular arrhythmia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner arten Covacany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at tirrie of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🗹 No 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D36601

Division of Vital Records, P.O.

State Registrar

DHMH 17 Rev 06-2011

Maple Ave., Takana Park, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:00 a.M Harold S. Patmon August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 123 W. 29th Street n/a Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 214-58-9591 1 💢 M 2 🗆 F Months **Director** Usual Residence of Decedent items 23a or 28a-f show ner must be notified at filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 W. 29th Street 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Force "natural", or Completed by 1 ☑ Never Married 2 ☐ Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. African-American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation n/a (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 2 Harold Chee Delores E. Patmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Pigford/ Niece 2028 Westmoreland Street, Philadelphia, PA 19140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-25-2012 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wile Funeral Home P.A. of Halto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine sician and burial-transit physician s the burial Physician/Medical that the death certificate be Completed by has certificate Be မ

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown	23d. Date of delivery  Month Day Year						
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available						
		autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1  Yes 2 No	Hospital:  1  Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 KResidence 6 Other (Specify)							
27. Manner of Death  1 Natural 5 ☐ Pending 2 Accident Investigation	(Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	sician: To the best of my knowledge, death occurred at the time, date and place, ar							

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0076786

, M.D., 123 Roeslor Rd, (, (en bene, m) 21060

08-24-2012

Certificate:

Medical

State Registrar

only one) 29b. Signature and title of cortifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. KATZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27636 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 22, 2012 Paul Bernard Ouirk 11:15 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9 Rambling Oaks Way, Apt. L Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Months Davs Hours 10/17/1944 018-36-1739 Massachusetts 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Rambling Oaks Way, Apt. L 21228 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married White 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Information Technology Computer Programer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thomas Quirk, Jr. Mary Elizabeth Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Van Ness Road, Belmont, Massachusetts 02478 Anne E. Quirk / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 8/24/2012 ☐ Denation 5 ☐ Other (Specify) Atlantice Crematory Glen Burnie, Maryland 21 Si natir e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ischemic Heart Disease vears Due to (or as a consequence of) COPD 2 years Due to (or as a consequence of): 23d. Date of delivery

Physician/ Medical Examiner

Exami

Department of H Important: If ite any injury or ot Page 1

Physician/

Examiner

**Funeral** 

Director

or 28a-f show notified at

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death

be filed within 72 hours after

Baltimore, Maryland 21215-0036

ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I

and Mental Hygie is marked other

other traumatic 1 and 2 should b if Health and Mer item 27 is mark

Director

Funeral

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Completed

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Medical

10a. State

MD

and attending physician for use as the buria Physician/Medical signed by the a þ Completed peen has page 2 within 24 hours after death.

To the Funeral Director: After this certificate Be ပ funeral Certificate: filled in by

death certificate be P.O. Box 68760

Division of Vital Records,

the Hospital or Attending Physician: The law

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 XNatural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 29a. Certifier [XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌

29c. License number

D 26294

405 Frederick Road, Suite 11, Catonsville, Maryland 21228

29d. Date signed (Month, Day, Year) 8/24/2012

10

State Registrar

DHMH 17 Rev 7/2009

AUG 2 9 2012

Medical

29b. Signature and title of cert

Luis M. 31. Date filed (Month, Day, Year)

30. Name and address of person w

Zunigą

M.D.

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ROWE ADELE 4 ugust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** <u>Baltimore City</u> If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 18, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 🗆 M 2 💢 F 217-34-7274 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore County Maryland Director 1 Yes 2XXNo 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5435 Moores Run Dr. 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2√√X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2√XNo <u>خ</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) N/A Homemaker Homemaking-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Kozlowski Frances Marzec 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5435 Moores Run Dr. Baltimore, Md. 21206 Raymond J. Rowe (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 8-31-2012 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is yearling to immodule cause. Enter Underlying Cause (Disease or injury that initiated events coulting in doubt less. Examine Directo for as a purseouspes of: burial-transit or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for 2 Fetal death in the past 12 months? Month Day 5 Other (specify) 1 | Yes | No 9 | Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ģ HYPERTENSION, HYPERLIDDEMIA 1 🗌 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 ☐ No Be 26. Place of Death | Check on | one Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: eral Director: After filled in by the funer 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 3 Suicide Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled i the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000

Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SUJAY State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

AUGUST 26 2017

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATHAK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Daniel F. Rasinski, Sr. 2012 August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 300 West Arden Road Brooklyn Park Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 216-36-6015 1 X M 2 🗆 F 72 October 19, 1939 Maryland Usual Residence of Decedent show 3a or 28a-f shov t be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 1 Yes 2X No Maryland Anne Arundel Brooklyn\_Park 10e, Street and Number 10g. Citizen of What Country? ms 23a Funeral 300 West Arden Road 21225 United States items 2 "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 10 Lithographer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Edward Rasinski Sophia Saltinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Rasinski/Wife 300 West Arden Road, Brooklyn Park, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot August west Arundel Crematory 1 Burial 2 T Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licenses MO1386 23a. Part 1. Enter the disease, or demplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List o Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran attending physician and certificate be exec Due to (or as a consequence of): Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death been signed by the a should be detached 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Yes ျှ 1 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident M Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 29b. Signature and title of certifier

Tarvin 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glen Buenic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Fer DVR G930 8/29/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month George Rode July 27 2012 1:12 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) **Director** 212822562 1**XX** M 2 □ F 52 Feb 6, 1960 Usual Residence of Decedent MD show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 XX No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral must be 245 A Woodhill Dr. 21061 USA items ? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ō P A 1xx Never Married 2 Married ☐ Yes Yes, Give 2 XXVc Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: "natural", Completed 3 Widowed 4 Divorced Specify. Year or Dates. USA Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Security CES Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental F marked of မ Charles W. Rode, Sr. Margaret M. Winterling and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Charles Rode, Jr. Brother 935 Longview Ave., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory July 31, 2012 Baltimore, MD Signature of Ineral Service License 22 Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 17-1 becomeny Taxease disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Pregnant at time of death Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate! performe 1 Yes 2 No Yes 2 No Be ( 25. Was case referred to medica 26. Place of Death (Check only one) 1 Ves 2 □ No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: Terms best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D4100 ess of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive Glen Burnie, Maryland 20161 Todd Rosen

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aug 2012 Irene Mary Ruff 8:28 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Center Baltimore Towson If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 216-16-2468 1 □ M 2 🔀 F Sept. 13, 1924 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified et 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dundalk. 1 ☐ Yes 2 🔀 No Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21222 United States 7860 St. Gregory Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+ 12 Years Accounting Clerk State of Maryland Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Bertha R. Maciejewski George Plum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Ruff (Husband) 7860 St. Gregory Drive Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem.8/31/2012 Dundalk, Maryland 21. Signature of Fugeral Service Licensee Mark Williams <sup>22</sup>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ehysician/ disease or condition resulting in death) ular ears Medical Due to (or as a consequence of) Êxaminer Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) \( \text{VSF} \) ( \( \text{P} \) ဂ္ 1 🗆 Yes 2 🖵 No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105 Baldmore Part chanes 701 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **AUG 29** Registrar

## Please Type or Print in Black indelible lnk. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 10:30AN HUGUST **ALEXANDER** RICE /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE PIKESVILLE COURTLAND NURSING HOME If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Funeral **X**□ M 2□ F Months Deys Hours Yrs. Director SC 11-26-1923 213-20-0660 88 permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental hygiene.
Important: If term 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, im Manical Examiner must be notified as 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits MD BALTIMORE PIKESVILLE 1XYes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 507 SHAMROCK LANE 21208 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes X No Specify: Specify BLACK ğ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL 8 STEEL WORKER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNIE MARGIE WATSON JAMES RICE 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 507 SHAMROCK LANE, PIKESVILLE, MD 21208 MRS. ZELMA RAWLINGS/DAUGHTER 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 8/30/12 BALTIMORE, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Fecility JAMES A. MORTON & SONS F.H. INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Monsy disease or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner attanding physician and for usa as the bunal-transit Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of-death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown Division of Vital Records, Be Completed by page 2 should be 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? certificate 1 Tyes 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certificatilled in by the funeral director. 25. Was case referred to medical 26, Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, efc. (Specify) 4 Homicide To the Hospital
within 24 hours of
To the Funeral I
completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner as stated. (Check only Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer, Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 197 32. Registrer's Stanature 31. Dete filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27642 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Charles Snyder 2012 010 M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pleasure Cove Marina Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **₹** M 2 □ F Hours 216 74 1104 M17037 1961 Country) Mary land Director Usual Residence of Decedent show or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A Maryland Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 3834 St. Margaret Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Dance Brothers Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Thelma Burch ပ William Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert C. Lemon / 2905 Charleston Avenue Halethorpe, Maryland 21227 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 08/28/2012 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, by one cause in each line. 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician. ruo disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the aid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No ၉ 4 Nursing Home 5 Residence 6 K Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Boat Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work in 24 hours after death.

Reference All Funeral Director: All pleted filled in by the fu 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one)

State Registrar 29b. Signature and titl

30. Name and addr

31. Date filed (Month, Day, Year)

AUG 2 9 2012

eputy

ess of person who completed cause death (Item 23a) (Type, Print)

JONES

mr

29c. License number

America Ct 21035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ORIS SPRIGGS Physician/ 2, 11 144A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MERCY HUSPITAL SALTIMORE N/A 8. Date of Birth (Month, Day, Year) Jul 4, 1933 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X F Country) Md Director 215-28-1214 79 Usual Residence of Decedent ems 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 □ No **Baltimore** MD **Baltimore City** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 4512 Manorview Road items? permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore **Administrative Assistant** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frances Jones Bernard Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4512 Manorview Road. Baltimore, MD 21229 Andrea Spriggs 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Aug 28, 2012 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Signature of Funeral Service Licens Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between DISEASE shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHERO'SCLEROTIC Onset and Death CARDIOVASCULAR Physician/ disease or condition Medical resulting in death) Examiner ReNAC DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last physicians the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ģ Pregnant at time of death Yes 2 No g Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manper of Death 28a. Date of injury 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Tes 2 No Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, value and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 PLACE PAUL 0.

Registrar

ST

State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Shirley Sheldon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4301 Cortez Road Baltimore 7. Age (In yrs. last birthday) 5. Social Security Numbe 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Davs Hours Min 216-34-3448 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director Brooklyn MD Anne Arundel 10e. Street and Number 10f. Zip Code or items 23a or Completed by Funeral 4301 Cortez Road 21225 should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Deloss Montonev Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is Linda S. Belcher/daughter 4301 Cortez Rd. Brooklyn MD 21225 20a. Method of Disposition
1 ☐ Byria 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date metro Crematory or other in Metro Crematory 8/31/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Kirkley-Ruddick Funeral Home M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ to lune Medical resulting in death) Examiner Sequentially list conditions. Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed ue to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the aid be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed peen this certificate ☐ Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ဂ္ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one) 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD:

SAWHNEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> 4c. County of Death Anne Arundel 9. Birthplace (State or Foreign Country) 10<sup>10</sup>23<sup>1</sup>235 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business Industry School System Downs Phiffer 20c, Location - City or Town, State Catonsville MD Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sute 202.

27644

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State

GURMEET 31. Date filed (Month, Day, Year, 25 HOSAN

12-06316 Lovell Spencer

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State of Maryland / Department of Health and Mental Hygiene 2012 27645 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 21, 2012 **Medical Examiner** 2348 hrs Lovel1 Spencer. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Foreign Davs Director 214-37-7670 1 M 2 F 19 Yrs MD 9/19/1992 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c City Town or Location 1 X Yes 2 No MD Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1406 Lemmon Street 21223 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 3 Widowed f Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify: Black <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Student High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michelle Lovell Spencer, Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is injury or other traumatic 1406 Lemmon Street, Baltimore, Md. 21223 Michelle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/1/2012 Lansdowne, Md. Mt.Zion Cemetery 5 Other Specify: <sup>22</sup>Name and Address of Easily Pa 21. Signature of Funeral Service Licens 1300 Eutaw Place, Baltimore, Md 21217The ter the disease, or comilications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Multiple (2) Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be Hospital: 1 Other Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DDA this ပ္ 1 Yes 28a. Date of Injury (Month, Day,Year) Aug 21, 2012 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 1 Yes 2 ✔ No 5 Pending within 24 hours after death.

To the Funeral Director: filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 1700 Block of Cole Street, Baltimore, MD determined (Specify) Local Street 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 22, 2012 Allan 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006 12-06375

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nothy Smith		State of Maryland / Depa 1- For State Cel Registrar	artment of Health a rtificate of Death	ind Mental F	tygiene Reg.	No. 201	2 2764
Physic edical Exam		1. Decedent's Name (First, Middle,Last)			2. Date of Death Month	)ay Year	3. Time of Death 0248 hrs
edicai Exam	mer	Timothy Smith  4a. Facility Name (if not institution, give street and number)	4b. City. Town.	or Location of Deal	August 24, 2	4c. County of Death	
		508 Rose Hill Terrace	Baltimore			N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Is $212 - 56 - 2527 = 1 \color{1mm}{mmm} \color{1mm}		ear If Under 24Hi ays Hours Mi		MM/DD/YYYY) 9. Bir Foreig	
any		Usual Residence of Decedent  10a, State 10b, County 10c, City,	Town or Location				10d. Inside City Limits
<b>E</b>	_						1 X Yes 2 No
arylar 8a-f s	Director	10e. Street and Number	Baltimore 10f. Zip Code	)	10g.	Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once	튭	_3207 Magnolia Avenue	212	227	U	SA	
21215-0036  Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "matural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	S. 13. Was Decedent of I		Specify Yes or No-		can Indian, Black,
after (	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X			Specify: B1	ack
hours natur Exam	l be	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup during most of working li	pation (Give kind of ife. DO NOT use re	work done 10 tired)	6b. Kind of Business/I	ndustry
36 in 72 in dical	pet	Elementary/Secondary (0-12) College (1-4 or 5+)	D			D d	O
5-00 led with Hygiene other 1	Completed	12 17. Father's Name (First, Middle, Last)	Driver	18.Mother's Nam	e (First, Middle, Mai	Produce (den Surname)	company
21215-0036  11d be filed within 72 hours afte Mental Hygiene.  marked other than "natural", to event, the Medical Examiner.	Be (	Sherman SMith		Annie	Evans		
C od b a f	70	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Str	eet and Number or	Rural Route Numbe	er, City or Town, State	, Zip Code)
ore, MEss land 2 soft Health au If item 27 her traums		Vincent Evans 20a. Method of Disposition 20b. F	3207 Magno			ltimore, l	
imore, MD 2 Pages I and 2 shounent of Health and Niant: If item 27 is nor or other traumatic	ш		crematory or other place)	- "		·	·
Baltimore, permit. Pages l ar Department of Hee Important: If ite	7	4 Donation 5 Other Specify: M €  21. Signature of Funeral Service Licenses	etro Cremato	ry 8/	$28/201_{4}$	Catonsv	ille,Md.
Baltimore, ME permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traums	,	21. Signardie di Pulieral Service Licenses	Estep B	rothers	Funera	l Servic timore,M	e,PA d. 21217
Physician		23a. Part I. Enter the lise se, or complications that cannot the death.	Do not enter the mode of dying	g, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interva
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic Drug	Intoxication				Between Onset and Death
CXammer		or condition resulting in death)  Due to (or as a consequence of					
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	n.				
	ij	cause. Enter Underlying Cause (Disease or injury that initiated					
ed	Examiner	events resulting in death) Last Due to (or as a consequence of	7.				
50, te be executed sysician and burial - transit	Aedical	X UNPENDED AMENDED 23a,27,	28a-f,per me,g	2931 9-14	-12 sm		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ar death. rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the bunal - trans	Ned	IF FEMALE: 23c. If yes, outcome of pregr				23d. Date of delivery	
30x 6876 death certificate e attending phy for use as the l	Physician/M	past 12 months?	2 Fetal death 3	Ectopic pregn			ay Year
eath c atten for us	/sici	1 Yes 2 No 9 Unknown 9 Unknown	ath 5 Other (Specify)				
D. B. t the de by the ached f	. 1	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause	e given in Part I.	23e. Did toba	cco use contribute to	he cause of death?
P.C. ires that signed I be deta	g S	<u></u>			1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
rds requi	Completed				24a. Was an autopsy		opsy findings available
ecc he law ate has					performe	d? death?	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical	26.Pla	ce of Death (Check			
Vit bysici this c	10 B	Tes 2 No	ER/Outpatient 3 DOA	Other Nursi	ng Home 5 Re	sidence 6 🗸 Other	Scene
ling Phy After ti funeral		(Month, Day, Year)		jury at Work?	28d. Describe how	injury occurred	
Division In or Attendii Is after death. In Director: A	뷿	2 Accident Investigation fd 8-24-12	raz:30 am	Yes 2 X No	unknown		
Division points of the cours after detail Direct filled in by	Certification:	Suicide determined (Specify) Fd:Resi	ome, farm, street, factory, office dence	building, etc.	28f. Location (Stre or Town, State	et and Number or Rui e) 508 Rose	al Route Number, City Hill Terr.
Div Hospital or 24 hours afte Funeral Di tely filled in		29a. Certifier		date and place, and	Raltimore		d
p the signal	Medical	one) 2 Medical Examiner: On the basis of examination an					
To To Corr	ĕ.	29b. Signature and title of certifier	29c. Licer	nse number	29	9d. Date signed (Mor.	th, Day, Year)
		in her	0.0	C.M.E.	A	August 24, 2012	
		30. Name and address of person who completed cause of death (Item	23a)				
		Ling Li, MD Assistant Medical Examiner 900 V		altimore, MD 2	1223		
	ate	31. Date filed (Month Day Year) 32. Registral's Signatur	re d'are				
Regis		ATT OF THE COMME	P. Parket				
MH 17 Rev 1/2	001		ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 6:35P LOUISE VIRGINIA SIEGMAN 2012 AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 29, 1923 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral MD. 220-22-4122 **Director** 1 □ M 2xxF 89 Yrs. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland Director Baltimore County 1 Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21220 1109 Washington Irving Lane Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaking⊸Own Home Ň/A Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Hill Casper Martin 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Rev. Charles G. Siegman 1109 Washington Irving Lane Balto., Md. 21220 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Dulaney Valley M. G. 9-1-2012 XX Burial 2 Cremation 3 Removal from State Baltimore. Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimorre, Md. 21236 22. Name and Address of Facility 21. Spran re of Funeral Service Licensee 7460 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final rolec Priysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No ours after death. eral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 No hospile 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my onlines death according to the cause (s) and manner as stated. Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

MARVES

31. Date filed (Month, Day, Year)

M

32. Registrar's Signature

Tawson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DAVID, STRINGFELLOW **Physician** 21:15 2012 AUGUST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Jan. 18, 1947 Mississippi 65 Director 426-88-3966 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show aţ 1 ☐ Yes 2X No Director ir than "natural", or Items 23a or 28a-f s the Medical Examiner must be notified Hanover Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21076 United States Funeral 1924 Pometacom Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: ð 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Officer Department of Defense 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ollie Stringfellow Jemmye Louise Moak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kay M. Stringfellow / Wife 1924 Pometacom Drive Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory of other place)
Arlington National
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 17, Department of Important: If it any injury or conce. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Arlington, Virginia 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Juneral Service License 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Gause (Final disease or condition a. EM CAND) (Final disease or condition a. EM CAND) (Final disease) **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed iding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760€ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown CARDIOMYOPATHY VENTRICULAR TACHTCARDIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page rector, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 Mal Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$  Other (Specify) 1 ☐ Yes 2 No funeral dir မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation Injury T Yes 2 No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

after death. Director: Af ģ 24 hours at Funeral D letely filled i within 24 hor To the Fune completely fi

(g)

DHMH 17 Rev 1/2001 11595

4 - Homicide

29b. Signature and title of certifier

MATTHEW 31. Date filed (Month, Day, Year)

29a. Certifier

Medical

State Registrar 32. Registrar's Signature

and manner statéd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

AUGUST 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27649 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month 08 Stum 0950 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Director 236-74-0462 1 X M 2 🗆 F 64 Yrs. March 20,1948 West Virginia Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f sho 7 Ts marked other than "natural", or items 25a or 28a-f sho raumaite event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21144 United States 7814 Elberta Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working United States life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Senior Electrical Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ L. Kathryn Gray Alphonsus M. Stum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or after 7814 Elberta Drive, Severn, Maryland 21144 Mary Wilson Stum/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 2, X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant View Memory 4 ☐ Donation 5 ☐ Other (Specify) Kearneysville, WV Gardens Signature of Funeral Service icensee Donaldson Funeral Home & Crematory, P.A. Will Et Pones 1411 Annapolis Road, Odenton, Maryland 21113 M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ischemic Medical Due to (or as a consequence of) Examiner Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Retroperitoneal Sarcoma
Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the ar Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CAO, HTN, DM 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 X No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer Natural Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D0057149 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr Glen Burnie MD 21061

Registrar

DHMH 17 Rev 06-2011

State

Saltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death 5:15 A M Physician/ 40101 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5725 Miami Court Howard Elkridge Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 181-16-7999 Months Davs (Month, Day, Year) Hours Director 1 M 2 X F 90 Yrs 11-18-1921 Pennsylvania Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Elkridge 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5725 Miami Court 21075 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ፩ ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed If Yes. Give 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Majko (unavailable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary A. Irvin - daughter 5127 South Rolling Rd., Relay, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park: 08-29-12 Elkridge, Maryland 21. Signature o 22. Name and Address of Facility Gary L. Kaufman Funeral Home at uneral/Service/Lig MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the at Id be detached fo Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ Division of Vital Records, Completed been si 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performe death? 1 ☐ Yes 2 ☑ No 1 Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 (1 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann f Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Aft id in by the fur work?
1 Yes 2 Accident
3 Suicide M 2 🗌 No Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type

31. Date filed (Month, Day, Year)

		for State		artment of Health and N	Mental Hygie		0776
		Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Death		.No. 2012	
Physic	ian/	Sung Yun	SHIN		2. Date of Death	Day Year 2012	3. Time of Death 1907 PM
Exam		4a. Facility Name (if not institution, give street and no	,	4b. City, Town, or Location of Death	-1 3	4c. County of Death	
Funera		Howard County General 1  5. Social Security Number 6. Sex	10Spital 7. Age (In yrs. last birthday)	Columbia  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Howard	alana (Odada an Familia)
Directo		216-96-2100 Ú\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	85 Yrs.	Months Days Hours Min.	Aug. 10,	1927 Cour	Korea
and show at	٦	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
Maryla 28a-f	Director	Maryland Howard	Ellic	ott City			1 Tes 2 No
with the is 23a or rust be n	Funeral D			10f. Zip Code 21043	10g	. Citizen of What Cou USA	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fur	1 Never Married 2 Married 1 Yes	orces? 3 2 <b>X</b> No ive	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  □ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: AS	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Seconday (0-12) College	(Give life. D	dent's Usual Occupation kind of work done during most of work O NOT use retired) WNET	ing	Kind of Business Industry	
yland 2 Id be filed w Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Shin Wan Soon			e (First, Middle, Maid Wan Tha	den Surname)	
Mar and 2 shou tealth and im 27 is m her traum		19a. Informant's Name/Relationship (Type, Print) Charles Kim — Grandson		ng Address (Street and Number or Rura Wethered Drive,			
Baltimore, bermit. Page 1 and Department of Hea Important: If item: any injury or other		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)		ge Mem Park 08/2	4/2012 E	c. Location - City or To 1kridge,M	laryland
Bal permi Depar Impo		21. Signature of Ineral Service Censeel	M01283 7	2. Name and Address of Facility Ga 250 Washington B1	vd., Elkr	idge, Mary	land 21075
- Ph <sub>sician</sub>		23a. Part 1. Enter the disease of complications that shock, or heart failure. List only one cause on a Immediate Cause (Final disease or condition	caused the death. Do not entereach line.	er the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
Medica Examine	r	Sequentially list conditions b.	o (or as a consequence of):				
suted nd ransit	Examiner	if any, leading to immediate  Cause (Disease or linjury that initiated events  C.					
760 cate be executed physician and the burial-transit	edical E	resulting in death) Last Due to	(or as a consequence of):				
be death certificate death certificate death certificate death certificate death dea	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
IS, P.O. uires that the signed by all be detact	þ	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the	
<b>DIVISION OT VITAI HECONDS,</b> ral or Attending Physician: The law requires 's after death. 11 Director: After this certificate has been sig ed in by the funeral director, page 2 should b	Completed				24a. Was an autopsy performed	prior to coldeath?	psy findings available mpletion of cause of
Ital sician: certific rector,	Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No Hospital:		26. Place of Death (Check	only one)		
OT V g Phys er this ieral di	e: To	27. Manner of Death 28a. Date		t 3 \( \text{DOA} \( \) 4 \( \text{Nursing Ho} \)  28c. Injury at	me 5 Residence 28d. Describe how in	e 6 Other (Specify)	)
iendin eath. or: Aft	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	nth, Day, Year) injury	work?  M 1  Yes 2  No			
DIVIS ital or At Irs after d ral Direct		1 Homicide determined 28e. Plac	e of Injury - At home, farm, stre ling, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
DIVISION OF VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the batter only one) 3 Certifying Nurse Practioner	sis of examination and/or invest	iccured at the time, date and place, an igation, in my opinion, death occurred at leath occurred at the time, date and place	the time, date and pla e, and due to the caus	ace, and due to the cau se(s) and manner as sta	use(s) and manner stated. ated.
<b>5</b> ≥ <b>6</b> 0		29b. Signature and title of certifier		29c. License number	90	Date signed (Month, L	012
		30. Name and address of person who completed cau	44 50	rint)	Lere, C	alertic	MS 21044
St Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 2 9 2012	Registrar's Signature	Kel			

State of Maryland / Department of Health and Mental Hygiene 2012 27652 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month **Medical Examiner** Month Day August 23, 2012 1342 hrs Alfreda Sigee Joyce 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3251 Yosemite Avenue Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Director** Months Davs Hours Min. 02 22 46 267-64-8723 66 SC 2 X F 1\_\_\_M Country) Yrs Usual Residence of Deceden any 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD Baltimore NA 1 X Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or teems 23a or 28a-f sho
rijury or other traumatie event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3251 Yosemite Ave 21215 U.S.A. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White etc. 2 X No Yes 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 No specify: Specify: <u>۾</u> Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 5yrs+ Teacher Schools Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Richard Ravenell Lillian Campbell 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38940 Camelot Way, Avon, Ohio 44011 Anthony Baker-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/29/2012 On-Site Baltimore, Md Donation 5 Other Specify. nature of Funeral Service Licensee Marcand Address of Facilitys t 4300 Wabash Ave, Baltimore, Md 21215 **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval /Medical Between Onset and a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed d Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b 2 Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed certificate h death? Yes 2 V No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 V Yes 2 No 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: / 5 Pending 24 hours after death. 1 Yes 2 No 2 \_ Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) determined within 24 hours a 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 24, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State MIG 29 Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2:28 PM DWIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. 1 X M 2 🗆 F 75 1 1 / 04 / 1 936 Guyana 055-48-6533 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Prince George's Maryland Upper Marlboro 1 ☐ Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20774 U. S. A. 106 Cameron Grove, Apt. 106 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 0. ρ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Black "natural", 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Police Officer/ 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Investigation/ Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Lorrilard is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Olga Agatha Skeete Prince Edward Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other tra 106 Cameron Grove, Apt. 106, Upper Marlboro, MD 20774 Evelyn M. Solomon/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Natl. Mem Park 8/30/12 Laurel, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature Funeral Service Licens 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End stage Liver disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Alcehour Cirrhos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ⊬ 9 ☐ Unknown Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** funeral director, Be Hospital 2 No Other: 1 Yes ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury nours after death.

neral Director: Aff
filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Funer completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29 c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records.

1070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 2 9 2012

RAZA

32. Registrar's Signature

D68222

AF242, 2001 Medical Parkway, Annapolis, MD 21401

08/23/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08/25/2012 Kimberly Alise Spence 10:25A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7155 Harp String Columbia Howard Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) Davs Hours 215-76-2522 Director 1 M 2 X F 47 04/25/1965 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7155 Harp String 21045 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black. White, etc 0 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify tem 27 is marked other than "natural", other traumatic event, the Medical Exa If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Years 2 Baker Bakery æ 17. Father's Name (First, Middle, Last) th and Mental F. 7 is mark 18. Mother's Name (First, Middle, Maiden Surname) ျ Rosalie Cornish Robert Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Rosalie Spence/mother N.Collington Ave.Baltimore MD.21231 20a. Method of Disposition 20b. Place of Disposition (Name of 0 4 / 1 2 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 09 / 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Hanover, Maryland Cremation Center 4 ☐ Donation 5 ☐ Other (Specify) φf MĎ. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral home 5240 Reisterstown Rd. Baltimore MD.21215 alle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical consequence of): Examiner Securentially list possible Examine if any, leading to immediate cause. Enter Underlying Due to or as a consequence of) executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown ģ Month detached the by signed d be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause iven in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy page performed? certificate Yes 2 XX funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 10 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No J Director: Af Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital within 24 hours To the Funeral Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

30. Name and add

31. Date filed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death onth Physician/ Medical (adlity Name (it of institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days (Month, Day, Year) 214-73-2725 Director 1 🗆 M 2 🔀 F 76 June11.1936 Ukraine r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 No Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 Associated Way, Apt. 421 21117 Ukraine 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 4 Building Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miron Maleev Elena Maleeva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Slootsky: Daughter Supreme Court, Owings Mills, Maryland 20b. Place of Disposition (Name of Crommetry Promatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 8-28-12 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Center of Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter University Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No r this certificate heral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ဂ္ 1 Yes 2 💢 No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 
Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

likol Smi		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death	
Physicia		Reg. No.  1. Decedent's Name (First, Middle,Last)  2. Date of Death	3. Time of Death
Examir		A service of the serv	1638 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De	eath
	4	Frederick Memorial Hospital Frederick Frederick Frederick	
uneral irector			reign Country)
	Ì	Usual Residence of Decedent	
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28a-f show d at once.	ģ		1 Yes 2 I
Mental Hygiene marked other than "natural", or items 23a nr 28a-f sho c event, the Medical Examiner must be notified at once.	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What C  21701  10g. Citizen of What C	country?
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items ust be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc	nerican Indian, Black, c.
	by F	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: B	LACK
atura Xami	핥	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Busines	ss/Industry
an "n	ete	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  RETAIL - ASSISTAN; MANGER RETAIL	u_
an of Health and Mental Hygiene.  1t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	TE IN TECHNIC - 703/37/1/37 4	
al Hyger of the tr, the	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  RONALD W. SMITH JR.  KURTRINNA M. Mc CAN	./. !
Ment mark		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta	
27 is	7	RONALD W. Smith JR (FIN) 1534 LAUREL WOOD WAY FREDERICAL  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery)  Date  20c. Location - City	
Healt item	1	20a. Method of Disposition	or Town, State
nt: In	- 1	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Resthaul Mem. Guiden Jug 9, 2012 Redevi	the Med.
Department Important: injury or ot	t	21. Signature of Funeral Service Mensee 22. Name and Address of Facility Contact Conta	
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State Registrar

31. Date filed (Month, AUG 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALIQU OSE MARIE 2012 Medical SMMERS Examiner 4a. Facility Name (if not institution, give street and number, County of Death Buenie Baltimore ANNE Washington Medical Center If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 218-766126 Director 1 M 2 X F 28a-f show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑No 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral STEVENS RD permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Yes 1 ☐ Yes 2 ☑ No If Yes, Give Specify 3 Divorced Year or Dates WHITE SUM MERS. KOS Baltimore, Maryland 21215-00 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OMEMAKE Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bobby Montgomery, JIE, MD. 21060 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ODENTON, MO DAUGHERTY FUNERAL HOME ZLOOI MOUNTAIN RO. PASADER at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part 1. Enter the disease or compl shock, or heart failure List only one Interval Between Immediate Cause (Final Onset and Death Physician/ 100 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and the burial-trai resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? for the Hospital or Attending Physician: The law requires that the death Day signed by the at Id be detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an he Funeral Director: After this certificate has appletely filled in by the funeral director, page 2 and appletely filled in by the funeral director, page 2 and appletely filled in by the funeral director. 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Tes 2 X No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending death. 1 Yes 2 No Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital Records, P.O. Box 68760 To the

> State Registrar

only one) 29b. Signa

31. Date filed (Month, Day, 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Smith Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death **Examiner** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Hours Min. Country) **Director** 579-42-5525 1 🗆 M 2 🖾 F 79 Apr. 3, 1933 DC Usual Residence of Decede 28a-f show ıral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Upper Marlboro MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1077 Largo Rd. #412 USA 20774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceden. Armed Forces?

Yes 2 No 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: er than "natural", the Medical Exar Specify 3 Widowed 4 Divorced Completed Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed with...
-tal Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sprint should be filed with and Mental Hygien is marked other th 12th Customer Service Rep. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Estella Cheek Isaac Chapman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a: If item 27 is Upper Marlboro, MD 20772 5913 Cromwell Ct. Rachelle Kirk - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. injury or Resurrection Cemetery 8-30-2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Cameral Service Licensee Marshalld Marten Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Gause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): physician are s the burial-t Physician/Medical Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ pe ( Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 certificate has performed 2 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes ဂ္ 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No Investigation filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 3 Excertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause

Date filed (Month, Day, Year)

		_		partment of Health ertificate of Death		lygiene Reg. No. (	2012	27659		
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Leona R. Thompson		2. Date of Month	Death Day	201 <sup>Year</sup>	3. Time of Death <b>7:14</b> P M		
	Examin		4a. Facility Name (if not institution, give street and number) Glen Burnie Health & Rehab Center	4b. City, Town, or Location			ounty of Deatl			
	Funeral Director		5. Social Security Number  218-28-7927  6. Sex  1  M 2  F  7. Age (In yrs. last birthda, 78 yrs.	Months Days Hours	der 24 Hrs. 8. Date of S Min. 1 128th		9. Birt	hplace (State or Foreign intry) MD		
	nd now at	_	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or	Location				10d. Inside City Limits		
	Marylar 8a-f sl	Director	, , , , , , , , , , , , , , , , , , , ,	n Burnie				1 🗆 Yes 2 🗀 No		
	with the last 23a or 2	Funeral Di	10e. Street and Number 895 Laurie Lane	10f, Zip Code 21061		10g. Citize	n of What Co	untry? SA		
900	should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ed by Fu	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic  1 Yes 2 No Specific No Specifi			. Race - Amer Black, White ec <i>ify:</i> <b>wh</b>			
Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medica	Completed by	(Specify only highest grade completed) (Girls Flementary/Seconday (0-12) College (1-4 or 5+)	cedent's Usual Occupation ve kind of work done during m DO NOT use retired) Homemaker	nost of working	1 -	of Business l			
land 2	d be filed w Aental Hygi Irked other tic event, t	To Be	17. Father's Name (First, Middle, Last) Leo Dougherty		other's Name <i>(First, Midd</i> Thelma Sch	lle, Maiden Sui 1otthol				
	nd 2 should ealth and N m 27 is ma ier trauma		Mr Gilbert Thompson/husband 895	ailing Address (Street and Num Laurie Lane,				Code)		
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	position (Name of rematory or other place) ren Memorial	Date 8/30/2012	Glen	tion - City or Burni	e, MD		
Ba	permit Depart Impor any in		21. Sign week Suneral Service Licensee M01364	22. Name and Address of Fac 421 Crain Hwy	sE Glen Bu	Ruddic rnie M	Funer 2106	cal Home		
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Alzheimers Demen disease or conditions		as cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death		
تميدي	Medical Examiner		disease or condition resulting in death)  ATTENDED  Due to (or as a consequence of):							
	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or linjury							
	icate be executed physician and s the burial-transit									
3760	ficate b g physi as the b	Aedical	d							
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M		B		23	d. Date of deli Month	very Day Year		
, O.	requires that the der been signed by the s should be detached	<u> </u> &	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Pa				the cause of death?		
ords	require been s should	leted			24a. W			obably 4 L Unknown opsy findings available		
Rec	sician: The law i certificate has b irector, page 2 s	Completed			1 🗆 Ye	rtopsy erformed? es 2 🖸 No	death?	ompletion of cause of		
Vital	/siciar s certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 ER/Outpat		Death (Check only one)  Nursing Home 5 Re	sidence 6 X	Other (Speci	Rehab Ctr		
on of	I or Attending Physician: T after death. Director: After this certifica I in by the funeral director, F.		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation  28b. Time (Month, Day, Year)  28b. Time (Month, Day, Year)	of 28c. Injury at	28d. Describ	e how injury or	ccurred			
Division of Vital Records,	tal or Attencrs after death al Director: , ed in by the	l Certificate;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		n (Street and N Town, State)	umber or Rur	al Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	estigation, in my opinion, death	h occurred at the time, da	e and place, ar	nd due to the c	ause(s) and manner stated.		
<b>-</b>	Toth with Toth		29b. Signature and title of certifier	29c. License numbe D21336	er		igned (Month	, Day, Year)		
	109		30. Name and address of person who completed cause of death (Item 23a) (Type		- 1	1 1 01	122			
	Stat		Albin Kuhn, M.D. 8028 Ritchie Hwy St 31. Date filed (Month, Pay, Year) 32. Registrar's Signature AUG 2 9 2012	iile 134, Pasa	adena, Mary	ıand 41	. 1 4 4			
	Registra	ır	TOUR OLUIC ( MANUAL M. MICHELLE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pierre J. Troy 918 Medical 4a. Facility Name,(if not institution, give street and nur County of Death Examiner Maryland General more If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth **Funeral** 9. Birthplace (State or Foreign Birthpic Country) MD 217-84-3490 1 X M 2 D F Min. Months Hours 10/31/60 **Director** Usual Residence of Decedent items 23a or 28a-f show ter must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Y Yes 2 No <sup>10f. Zip Code</sup> 21217 10e. Street and Number 1606 Lorman Ct 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ō ş 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 5-0036 frican Amer 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Land Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Helen Lockette Joseph W. Troy 19a. Informant's Name/Relationship (Type, Print) Mary Lawrence/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1634 E. Preston St., Balt., MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cem. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending ☐ Accident after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ander

DHMH 17 Rev 7/2009

Registrar

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27661 StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 RENEE TINSON 1430 p M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year) **Director** 578-78-5959 53 1959 DC 21, Apr. Usual Residence of Decedent Show within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 No Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4108 Rocky Mount Dr 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Divorced Specify. Completed Year or Dates **Black** the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Daycare Provider Daycare yrs. t of Health and Mental Hygilf item 27 is marked othe or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Dorothy Dykes Frank Tinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Tinson - Mother 4108 Rocky Mount Dr. Temple Hills, MD 20748 Saltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harmony Memorial Park 9-4-2012 Landover, MD 4 Donation 5 Other (Specify) Signature of Furneral Service Licenses Marshall MarchityFuneral Home of Maryland ular 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition resulting in death) Medical Examiner Due to (or s a consequence of: Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? certificate 1 ☐ Yes 2 ☐ No Yes 2 1 No Division of Vital funeral director, 25. Was case referred to predical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 12 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending ours after death.

neral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

MOBALAK A

29

610 CARROLL

- AVE, STE 340, TAKOMA PARK,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Peter Gregg,

31. Date filed (Month, Day, Year)

AUG 2 9 2012

1235 East Monument Street,

Baltimore.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Maryland		ificate of D			eg. No. 20	12 27663
L	Physicia Medi		1. Decedent's Name (First, Middle, Last)  LVGILLE WHITE				2. Date of Death Month NGUST		3. Time of Death 9:49 AM
	Exami		MEDSTAR HARBOR HOSPITA		4b. City, Town, or I	DRE CIT	Ϋ́	4c. County of I	Death N/A
	Funeral Director		5. Social Security Number 217 50 8677		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 08/23/	Year)	Birthplace (State or Foreign Country) West Virginia
	Aaryland Ba-f show tified at	Director		ty, Town or Loca Orchard			1		10d. Inside City Limits  1  Yes 2 No
	with the Ns 23a or 2s ust be no	Funeral Di			10f. Zip Code 2122	б	1	0g. Citizen of Wha	,
9036	s filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 X Married 1 Yes 2 X No		as Decedent of His Yes, specify Cuban ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. Thite
Maryland 21215-0036	within 72 hou giene. er than "nat er the Medica", the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kli life. DO	ent's Usual Occupat nd of work done du NOT use retired) istration	ring most of work	ing	16b. Kind of Busin Harbor	ess/Industry Hospital
land 2	ould be filed within d Mental Hygiene. marked other thal matic event, the M	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	laiden Surname)	110292002
, Mary	2 shoulth and the shoulth and		19a. Informant's Name/Relationship (Type, Print)  Charles White / Husband	8043	Address (Street ar Highpoint	Road			, Zip Code) Maryland 21226
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition  1	n Haver	ition (Name of atory or other place, n Mem. Pa	rk   08/2	7/2012		nie, Maryland
Bal	permit Depar Impor any in		21. Signate of uneral Service research of the Control of the Contr	40	01 Ritch	ie Highw	ay Balt	imore, Ma	ice, P.A. aryland 21225
market and the second	Ph_sician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequ	D INT	LAVASCUI	AR CO			Approximate Interval Between Onset and Death
0	ificate be executed g physician and as the burial-transit	cal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause of t	OID L	<u>Үмрном</u> г	4			3weeks
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Record	The law req ate has bee page 2 sho	Completed					24a. Was an autopsy perform 1  Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \( \square\) No
f Vital	Physician: The this certificate aral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2 It leads to finity 2 It leads to finity 2 It leads to 1 Inpatient 2 It leads t	ER/Outpatient 28b. Time of	LOthor	4 ☐ Nursing Ho	me 5 Resider	nce 6 Other (S	pecify)
Division of Vital Records,	ne Hospital or Attending Physician: The law requires that the death cert in 24 hours after death cert in 24 hours after death of the attendire the certificate has been signed by the attendire pletely filled in by the funeral director, page 2 should be detached for use	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be 4 Homicide determined (Month, Day, Year)  28e. Place of Injury - At hor building, etc. (Specify)	injury ome, farm, stree	M 1 ☐ Ye	es 2 🗆 No	28d. Describe hov 28f. Location (Stre City or Town,	eet and Number or	Rural Route Number,
۵	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (	29a. Certifier (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Physician: To the basis of examination	n and/or investig	ation, in my opinion,	, death occurred at	the time, date and	place, and due to t	the cause(s) and manner stated.
	To the com		29b. Signature and title of certifier	MD	29c. License r			Date signed (Me	onth, Day, Year)
	100		30. Name and address of person who completed cause of death (Item. RRCHANA NAIR , 300   SOUTH	23a) (Type, Pri	nt)				
	Sta Registr		31. Date filed (Month, Day, Year) 38. Registrar's Signate						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James Kevin Weeks 20/2 440457 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO TENINSULA REGIONAL MCCICAL SAL156414 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) 8 Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 220-70-9278 1 X M 2 □ F 54 Usual Residence of Decedent 11/25/1957 Washington, DC or then "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21802 U.S.A. 351 Deer's Head Hospital Road I Hygiene. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ፩ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 M Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maintenance Technician Hospitality Be permit, Pege 1 end 2 should be filed Depertment of Health end Mentai Hy Importent: If item 27 is marked out, eny injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patricia Ann McDermott Herbert Weeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Huntover Drive, Rockville, MD 20852 Susan Pistolas / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/28/2012 | Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Signature of Funeral Service Licensee Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Prrysician/ Due to (or y a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use es the burial-transit Hospitel or Attending Physicien: The law requires thet the death certificate be executed Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): the ettending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospitel or Attending Physicien: The law requires thet the death owithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the etter completely filled in by the funeral director, pege 2 should be detached for t in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) anja 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Bruce George Wawro 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death MSICEM MODIFIEDIZA (INTR 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Director 217-48-5315 1 ⅓M 2 ☐ F 09/22/1949 Usual Residence of Deceder 62 Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 364 Hickory Nut Court 21112 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 X Divorced White altimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ည Julius J. Wawro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose K. Hagan / Friend 716 Ponca Street, Baltimore, MD 21124 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 a Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 M Donation 5 ☐ Other (Specify Anatomy Gifts Registry 08/28/2012 Hanover, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CEPEBROYASCUL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed?
Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Mann f Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 2 Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to e and title of certifie 29b. Sanat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First Middle Last) 2 Date of Death Month Year James Warfield OIDI AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🗷 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 07/08/1937 216-34-4651 Mary land Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2618 Fleet Street 21224 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗷 No If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Appliance Repair Technician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Warfield Laura Reddish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3104 Baybriar Road, Baltimore, MD 21222 Regina Northrup / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 08/28/2012 | Hanover, Maryland 22. Name and Address of Facility 21. Signature of Fun I Service/Sicenses Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final

Physician/ Medical Examiner

certificate be executed physician s the burial

attending

signed by t 1 be detach

has certificate

24 hours after death.

Funeral Director; After this eated filled in by the funeral dir

within 2 To the I

Medical

29b. Signature and title of certifie

Sarah Ciccotto 31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

Physician/

Medical

Director

Funeral

Completed by

Be

2

Examiner

**Funeral** 

Director

show at

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once.

Saltimore, Maryland 21215-0036

notified 28a-f

with the Maryland

Examiner Physician/Medical

Completed by Be မ Certificate:

disease or condition resulting in death)	a <u>Sepsis</u>		1 i week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):  Due to (or as a consequence of):		1 week
that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)	
1 Yes 2 No	Hospital: 1	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, le)
(Check 2 \( \sum \) Medical Examin	sician: To the best of my knowledge, death occured at the time, date and place, at ner: On the basis of examination and/or investigation, in my opinion, death occurred a e Practioner: To the best of my knowledge, death occurred at the time, date and pla	t the time, date and plac	ce, and due to the cause(s) and manner stated

1063737518

Baltimore, MD

29d. Date signed (Month, Day, Year)

31203

08/23/12

State Registrar

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Charles Wieland State of Maryland / Department of Health and Mental Hygiene

2012 27667

		Registrar_		Ce	ertificat	e of	Death				Reg. No	).		
Physic Medical Exam		Decedent's Name (First, Midd Kennet	<sub>He,Last)</sub> h Charles W	ieland						2. Date of De Month August 2	Day	Year		3. Time of Death 2350 hrs
		4a. Facility Name (if not institution 752 Cactus Court	on, give street and n	umber)		41	o. City, Town, Millersville		n of Death		- 1	c. County of Anne Aru		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs			If Under 1 Your Months Da	ear If Ur	nder 24Hrs. urs Min.	1	·	ĺ	Foreig	
		Usual Residence of Decedent	1 M 2 F			Yrs.		<u> </u>		03-03	-1900	3	Col	untry) MD
nd Show any	Ļ	10a. State 10b. County Maryland Anne	Arundel	10c. Cit	ty, Town or M		n rsville							10d. Inside City Limits  1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number					10f. Zip Code	2110			10g. Cit	tizen of Wha	st Coun	try?
with the ms 23a c		752 Cactus C	12. Was De	cedent Ever in	U.S. 1:		Decedent of h		rigin? ( Spe		10-	14. Race -	Americ	can Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygien and Mental Hygien 27 b marked other than "natural", or items 23a or 28a-fab mastic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 X M 3 Widowed 4 Div	Armed F  1 Yes  /orced If Yes, Give Yes or Dates:	2 XX No			s, specify Cub Yes $2 \overline{X}$ N			Rican, etc.)		White, Specify:	Whi.	te
ours a turs	d b	15. Decedent's Education (Spe	cify only highest gra	de completed)			s Usual Occup				16b.	Kind of Bus	iness/Ir	ndustry
136 hin 72 hours afte e. than "natural",	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)			st of working li	fe. DO NO	)T use retire	ed)		Dri	ntin	g Company
with spene	mo	17. Father's Name (First, Middle	Lost)		1	rint	er	40 14-41		First, Middle	Maidan		шш	g company
21215-0036 uid be filed within 7 Mental Hygiene. marked other than	Be	Charles W.	Wieland, Jr					Ja	anis An	n Nykie	* 1 k	·		
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Fleath and Montal Etygene. East: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	To	19a. Informant's Name/Relations Valerie Wieland	thip (Type, Print) (Wife)		75	52 Ca	Address (Str Ctus Cou	rt 1		ural Route Nu sville,	Mary]	land 21	108	
more, ML Pages 1 and 2 s nent of Health at ant: If item 27 or other traum?		20a. Method of Disposition  1 Burial 2 X Cremation		rom State	Place of D crematory Lantic	or othe		emetery,		Date 3-2012	1	Location - (	•	rown, State Maryland
Baltimore, permit. Pages 1 at Department of Het Important: If ite injury or other tr		4 Donation 5 Other S, 21. Signifure of Funeral Service		710		22. Na	me and Addre	ss of Faci	lity Gary	L. Kau	fman	Funera	1 Ho	me
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the deat	th. Do not e									Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Gu	Inshot Wou		ad								Death
	ē	Sequentially list conditions, if any, leading to immediate	b	consequence	of):									
	Examiner	(Disease or injury that initiated events resulting in death) Last	С	consequence	of):	_		_			_		_	
760, cate be executed physician and he burial - transit		UNPENDED	dAMENDED											
8760, iffcate be ex ng physiciar is the burial	n/Medical										100			
68760, certificate be nding physicise as the buri	ξ	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pre		Fotal	I death 3	Ector	oic pregnan	CV	23	<li>d. Date of de Month</li>	elivery Da	ay Year
the death certification by the attending property the attending property.	Physicia	past 12 months?  1 Yes 2 No 9 Uni		ant at time of d	teath 5	_	(Specify)		oro program		10	Monar		ay roan
F, P.O. B ires that the d signed by the	by Ph	Part II. Other significant condit			resulting in	the und	derlying cause	given in I	Part I.			_	_	ne cause of death?
ds, F equires een sign										24a. Was				bpsy findings available
of Vital Records, bg Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed					-					psy ormed? 2 N	de	or to co ath? ✓ Yes	empletion of cause of
tal Rectant The certificate ector, page	BeC	25. Was case referred to medica					26.Plac	e of Deat	h (Check on					
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpa	atient :	3 🗌 DOA	Other <sub>4</sub>	Nursing	Home 5	Reside	ence 6 🗸	Other:	Scene
_ = = . ~ ⊒		27. Manner of Death  1 Natural 5 Pend	28a. Date (Month Aug 24,	of Injury Day Year) 2012	28b. Time 2320 hr	-	' I	ury at Wo	_  s	8d. Describe ubject sh			j	
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Coul	a not be	e of Injury - At I			factory, office	building,		8f. Location or Town, 52 Cactus (				al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only 1 Certifying Pt	nysician: To the bes		dge, death	occurre			place, and di	ue to the cau	ıse(s) an	nd manner a	s stated	
To the within To the comple	Medical	one) 2 Medical Example 29b. Signature and title of certifie	miner: On the basis of and mapners		and/or inve	stigation	n, in my opinio			the time, date				h, Day, Year)
		Melle K	half.	11				M.E.				just 25, 2	·	n, <i>Day,</i> real <i>j</i>
)		30. Name and address of person Melissa Brassell, MD	who completed caus Assistant Me			0 W.	Baltimore :	Street, I	3altimore	e, MD 212	23			
St Regis		31. Date filed (Month, Day, Year)	32.	aidher's Cianai										
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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27668 State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month LOUIS AUGUST 2012 ISRAEL WACHTER 24 09:30A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2700 STONE CLIFF DRIVE. BALTIMORE BALTIMORE Date of Birth (Month, Day, Year) 02/17/1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Hours 1 🕅 M 2 🗆 F Days 217-20-7934 85 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 27 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2700 STONE CLIFF DRIVE, #308 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER WHOLESALE HARDWARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL WACHTER REBECCA SHANE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 STONE CLIFF DRIVE, #308, BALTIMORE, JEANNE WACHTER / WIFE MD21209 20b. Place of Disposition (Name of cemplery, crematory of other place)
ANSHE KURLAND 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/26/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signatur of juneral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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MD

**Funeral** 

**Director** 

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

nt of Health a Department of Health Important: If item 27 any Injury or other troops.

Baltimore, Maryland 21215-0036

burial-tran attending physician for use as the burial signed by the a spital or Attending Physician: Thours after death.
Ineral Director: After this certificate if filled in by the funeral director, pa To the Hospital o within 24 hours af To the Funeral Di completely filled in

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	a. Anemia	L.	Moutes					
<u>.</u>	Sequentially list conditions, a.y. bath g to innectate cause. Enter Underlying	Due to (or as a consequency of):		norths years					
cal Lyanini	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Nurrut Sarcona  Due to (or as a consequence of):							
ly stellar in mean	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month D	ay Year					
ed by r	Part II. Other significant conditions co	3 · · · · · · · · · · · · · · · · · · ·	lid tobacco use contribute to the ☐ Yes 2 ☐ No 3 ☐ Probat						
oo iii bici		p	Vas an utopsy prior to composition of the composit	y findings available bletion of cause of □No					
3	25. Was case referred to medical examiner?	26. Place of Death (Check or	<del>'/'</del>						
2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ F	Residence 6 Other (Specify)						
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  28c. Injury at Work?  M 1 Yes 2 No	be how injury occurred						
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Locatic City or	n (Street and Number or Rural F Town, State)	Route Number,					
T C C C C C C C C C C C C C C C C C C C	29a. Certifier (Check only one)	rsician: To the best of my knowledge, death occurred at the time, date and place, and due to finer: On the basis of examination and/or investigation, in my opinion, death occurred at the ti- and manner stated.	the cause(s) and manner as sta me, date and place, and due to the	ted. ne cause(s)					

29c. License number

D257+3

-35 N. Charles St

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine C. Angle 08, Medical August 2012 11:00 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Lifespring Senior Housing Catonsville Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 89 Months (Month, Day, Year) Director 212-20-2309 1 M 2 X F Yrs. May 05, 1923 Maryland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200 Pleasant Villa Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 XNo If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 
Widowed 4 
Divorced Completed Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4 or 5+) 12 Analyst Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ၉ Phillip Reinhalter Catherine Oster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2619 Poplar Drive Gwynn Oak, MD 21207 item 27 Craiq Angle / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 20c. Location - City or Town, State ō **=**  5 1 Burial 2 Caremation 3 Removal from State 10. artment ortant: I injury o 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Baltimore, MD INC 2012 permit. P Decarting Imports any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CREMATION DIRECT Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) emonths Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No Pregnant at time of death Day signed by the at Id be detached for 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 X No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hin 24 hours after death.

the Funeral Director: After this
mpletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

only one

29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

		State of Maryland / Dep	artment of F			giene Reg. No 20	12 27670
Dhusisis	/	Registrar  1. Decedent's Name (First, Middle, Last)	rineate of L	Jean	2. Date of Dea	th	0.7
Physicia Medic	al	Jane L. Alena			Month O8	3 Day 03	Year 12 M
Examin	er	4a. Facility Name (if not institution, give street and number)  Atlantic General Hospital	4b. City, Town, or Berlin	r Location of Death		f Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I f Under 24 Hr.				Birthplace (State or Foreign
Director		177–50–8269 1 □ M 2 🗶 55 Yrs.	Months Days	Hours Min.	(Month, Day		Country) PA
land show	tor	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
746 th the Maryland 3a or 28a-f show	Direc	PA Berks Reading  10e. Street and Number	1				1 ☐ Yes 2 🙀 No
With th	<b>Funeral Director</b>	2715 Park St.	10f. Zip Code 19606			10g. Citizen of Wh	nat Country?
death items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?		ispanic Origin? (Spec in, Mexican, Puerto F	cify Yes or No-	14. Race -	- American Indian,
12 336 336 after a	d by	1 Ly Yes 2 \( \text{No}\)  1 Ly Yes 2 \( \text{No}\)  1 Fes, Give	1 Tes, specify Cuba		nican, etc.)		White, etc. White
3-05-06 Shours	Completed by	15. Decedent's Education 16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busi	
21216 21216 Within 72 iene. r than "	Som	Elementary/Secondary (0-12) College (1-4 or 5+) life. D	kind of work done d OO NOT use retired)	luring most of working	ig		,
nd 2	Be	12 CPA 17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, N		vice Company
ylan	일	George H. Koch		Shirley		,	
Maryland 21215-0036  Should be filed within 72 hours after death with the Maryland th and Martal Highene. It is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at				and Number or Rural			te, Zip Code)
re, land freath trem 2		20a. Method of Disposition 20b. Place of Dispo	osition (Name of	, Reading	, PA,	19606 20c. Location - C	ity or Town State
Baltimore, Maryland 21215-0036 bearti. Page 1 and 2 should be filed within 72 hours after appartment of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Examples.		1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Cemetery, crematery, cremat	matory or other place ills Memo:	e) rial 08-1			
Baltimore, Mispermit. Page 1 and 2 st Department of Health a longpartment if item 27 is any injury or other training or	-	21. Signatuli of Fun Lil Service Licensee 22	2. Name and Addres	ill Rd.,	loway F	uneral H	
56		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					Approximate
Physician/ Medical			Cell Co	ancer			Interval Between Onset and Death
Examiner		Due to (or as a consequence of):					
	iner	Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury					
executed an and rial-transi	xan	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):					
60 60 ate be executed hysician and the burial-transit	dical Examiner	d d					
68766 certificate nding physuse as the	Med	F FEMALE:				-4	
		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy	/		, 23d. Date of	· · · · · ·
G. B. S. B. S.	) NSi	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)			IVIOITI	Day 1eal
P.O. P.O. gned by be detail		Part II. Other significant conditions contributing to death but not resulting in the u		en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
Ale	ered	gastrointestinal bleeding metastatic Renal Cell Ca			1 🗆 Ye		☐ Probably 4 ☑ Unknown
eco le law e has b	сотріетей ву	metastalic Kenal Cell Ca	incer		24a. Was ar autops perforn	y prio	re autopsy findings available or to completion of cause of th?
/ital Reco		25. Was case referred to medical examiner?	26. Plac	ce of Death (Check o	1  Yes 2		Yes 2 No
Division of Vital al or Attending Physician: s after death. il Director: After this certificed in by the funeral director.	۹	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Oalhan			nce 6 🗆 Other (S	Specify)
and of Jon of Lending Pheath.	care	<ul> <li>17. Manner of Death</li> <li>1 ☑ Natural</li> <li>2 ☐ Accident</li> <li>Investigation</li> </ul> <li>28a. Date of injury         (Month, Day, Year)         injury     </li>	28c. Injury : work? M 1 \square		d. Describe how	w injury occurred	
isio	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stre			3f. Location (Str	eet and Number o	r Rural Route Number,
Division of Vital Records, P.O. Boy Division of Vital Records, P.O. Boy Hospital or Attending Physician: The law requires that the death 24 hours after death. Funeral Director. After this certificate has been signed by the atte tely filled in by the funeral director, page 2 should be detached for		building, etc. (Specify)			City or Town,	,	
Division of Vital Rec Division of Vital Rec To the Hospital or Attending Physician. The la within 24 hours after death. To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, only one)	igation in my opinion	death accurred at the	a time data and	place and due to	the earlies (a) and manner stated
To the within 2 To the comple	– r	9b. Signature and title of certifier	29c. License	number		cause(s) and mani d. Date signed (N	
		Carrennas WM Aitending	D5	6312		08/03	3/2012
STC!	1	10. Name and address of person who completed cause of death (Item 23a) (Type, Pr	eri un di l	Huway D	viva 7	Berlin, n	1D 21811
State		1. Date filed (Month, Day, Year)	1.1	1-			
Registrar		AUGUIT CLIMA & gar					

			For State	State of M	arylan					nd Mental	Hygie	ne			
			Registrar			Cer	tificate c	of Dea	ath		Reg	. No. 2	2	276	71
H	Physicia Media		Decedent's Name (First, Middle,     Samuel Lay	,	kins					Mon	of Death th ust 5	, 2012	ear	3. Time of D	n
many	Examir	ner	4a. Facility Name (if not institution,	·			4b. City, Tow	n, or Loc	ation of I			4c. County of	Death		
	/		504 Edgewater					isbu				Wicom	ico		
	Funeral Director		5. Social Security Number 214–28–3306		e (In yrs. la	ast birthday)	If Under 1 You Months Da				of Birth th, Day, Ye	ar) 9	. Birthpl Countr	ace (State or F	oreign
			Usual Residence of Decedent	1 🔀 M 2 🗆 F	84	Yrs.				09/	17/19	27		/land	
	show	b	10a. State 10b. County		10c. City	, Town or Loc	ation			1 - 1 /	/			d. Inside City	Limits
	Maryl 18a-f	Director	Maryland Wico	mico	S	alisbu	ry							1 X Yes 2	□ No
	a or 2		10e. Street and Number				10f. Zip Coo	de		<u> </u>	10g	. Citizen of Wha	t Count	ry?	
	s 23,	Funeral	504 Edgewater	Drive			218	304				USA			
98	parmit. Page 1 and 2 should be fliad within 72 hours after death with the Marylend Department of Health and Mental Hygians. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	ē	11. Marital Status  1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No	If	/as Decedent of Yes, specify C	Suban, M	exican, P	? (Specify Yes o uerto Rican, etc	or No-	14. Race - A Black, V			
용	atura cul E	Completed	15. Decedent	Year or Dates. A	Army						-	Specify:	_	ite	
5	72 h	를	(Specify only highes	t grade completed)	- 3	(Give k	ent's Usual Oc ind of work do ) NOT use retii	ne during		working	16	b. Kind of Busin	ess/Ind	ustry	
25	withir giana er the		Elementary/Secondary (0-12)	College (1-4 or 5	i+)	Mana						Food St	ore		
9	fliad al Hyg Loth	Be	17. Father's Name (First, Middle, La	st)				18.	Mother's	Name (First, M					
<u>Ş</u>	d ba Menta arkec	욘	A. Paul Adkins							e Layfi		ŕ			
altimore, Maryland 21215-0036	nd 2 shou aaith and m 27 is m		19a. Informant's Name/Relationship Mary F. Adkins/	o (Type, Print) Spouse						r Rural Route N Salisbu				ide)	
Ore	t of H lf Ite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Pl	ace of Dispos	ition (Name of atory or other	place)		Date	200	. Location - Cit	y or Tow	n, State	
Ë	t. Pag tman tant:		4 ☐ Donation 5 ☐ Other (Sp	ecify)	For	est Gr	ove Cer	neter	ry 8	/14/201	2 P	arsonsb	urg,	MD	
Ba	Dapar Dapar Impor any Ir		21. Signature of Furneral Service Lic	Slaw	6	Ho 50	Name and Ad DILOWAY DI Snow	dress of Fun Hil	eral 1 Rd	Home P	rofes sbury	ssional 7, MD 2]	Ass 804	ociatio	on
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused ly one cause on each line	the death	. Do not enter	the mode of	dying, su	ch as car	diac or respirate	ory arrest,			Approximate nterval Between	en
F	mysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a			Lym	PLU	14					Onset and Dea	
	Examiner	Ш	resulting in death)	Due to (or as a	conseque	ence of):									
		힐	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	CORSECUE	ence off:									
	icata bs axecutad g physician end ss tha burlal-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury	200 10 (0. 40 0	. oondoqu	arioc 61/j.									
	n enc	ă	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):							+		
09	a bs a yslcia ia bur	edical		d											
876	Ificata ig phy as th	Med	IF FEMALE:												
Division of Vital Records, P.O. Box 68	Tha law raquiras that the death certificate bs executed ate has been signed by the attending physicien end page 2 should be deteched for use as the burlel-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 3 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal	death 3	Ectopic pregn Other (specify					23d. Date of Month		/ ay Year	г
0	that t nad b a date	by P	Part II. Other significant condition	s contributing to death bu	ıt not resu	Iting in the un	derlying cause	given in	Part I.	23e.	Did tobacc	o use contribut	e to the	cause of deat	h?
rds,	raquiras baen sigi should bu	eted k									1 🗌 Yes	2 No 3 E	Proba	bly 4 🗆 Unk	nown
Reco	0	Completed								-	Was an autopsy performed Yes 2	2 prior deat	to comp	y findings avai detion of caus	lable e of
<u> </u>	siclan cartif recto	8	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:			1	Mb		Check only one)					
<u> </u>	raldis	٩	27. Manner of Death	1 ☐ Inpatie		R/Outpatient 28b. Time of	3 LI DOA		☐ Nursir	ng Home 5			oecify)		
noi	ttending daath. :tor: Aftal / the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigar 3 Suicide 6 Could no	(Month, Day,	Year)	injury	M 1		2 🗆 No		ribe how in	jury occurred			
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	the Hosp thin 24 ho the Fune mplataly f	Medical	only one) 3 Certifying N	thysician: To the best of naminer: On the basis of extures Practitioner: To the	amination a	and/or investig	jation, in my op	sinion, dea	ath occur	red at the time, o	late and pla	ice, and due to t	he cause	(s) and manne	r stated.
_ '	5 <b>5 6</b> 8		29b. Signature and title of certifier	16/2			29c. Lice	nse numi	ber		29d. l	Date signed (Mo	onth, Da	y, Year)	
		-		<i>V</i> 1				04'	1091	<u> </u>		8/6	/12_	_	
	106		30. Name and address of person wh	to completed cause of de ATT SAN 2012 32. (egistrar	24/	23a) (Type, Pri	D/V 15/U	~ .	shew	440	153UB	y u	D 21	804	
	Stat Registra	_		2012 32. fegistrar	s Signatu	2 po	able								

State of Maryland / Department of Health and Mental Hygiere 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician August 15,2012 Year Mary Catherine Berkenbaugh 7:40 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Coffman Nursing Home Washington County Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 214-09-0472 100 Yre Nov. 2,1911 Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Co. Director Hagerstown 1 Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? item 27 is marked other than "netural", or iteme 23s or other traumatic event, it a Medical Exeminating must be a 1304 Pennsylvania Avenue **USA** 21742 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hyglene. Int: If item 27 is marked other than "netural", or Itel Black, White, etc. 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 🗓 No Specify: 3 N Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Claim Adjuster State Government 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward H. Rang Myrtle A. Hare 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Thompson-Smith / Daughter 1417 Glennwood Avenue, Hayerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any Injury or once. Rest Haven Cemetery Aug. 20,2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sunature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, MD un 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Onset and Death fmmediate Cause (Final disease or condition resulting in death) CEREBRO VASUUUM **Physician** MUDENT 2-3 DAYS /Medical Due to (or as a consequence of): Examiner DEBILITY YEARLY HOSPILE COME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? within 24 hours after death.

To the Funeral Director: After this completely filled in 1. 1 ☐ Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 fnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) HAGENSTOUN 1190 ALTWA ROM MI 31. Date filed (Month, Park Year) 32. Pristrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ August Thelma Louise BOWARD 02:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs Days Hours Min Director 1 □ M 2 🕅 F 214-28-6101 Usual Residence of Decedent 90 March 31, 1922 Maryland 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Washington Funkstown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 200 E. Poplar Street 21734 USA items ; Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify White 3 X Widowed 4 Divorced Specify: marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 6 <u>Laundry Worker</u> Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ of Health and Menta f item 27 is marked r other traumatic e Albert Walter Drury Lula Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jeannie Hendrickso</u>n/Daughter P.O. Box 411 Funkstown, Maryland 21734 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park |8/22/2012 Hagerstown, Maryland Funeral Service Licer 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on eacy line. shock, or heart failure. List only one cause on eac Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year detached 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No upletely filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certif Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) State Registrar

12-06140	
Mary Elizabeth Bergman	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 27674
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate c	of Death	Reç	g. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)			Date of Death     Month		3. Time of Death 1705 hrs
edical Exami	ner	Mary Elizabeth Bergman  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	Month August 15,	2012 4c. County of Death	17051115
		Western Maryland Hospital Center		Hagerstown		Washington	
Funeral Director		179-30-3881 1 M 2XF 77	(In yrs. last birthday) Yı	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	(MM/DD/YYYY) 9. Birt Foreig Cou	
any		Usual Residence of Decedent  10a. State 10b. County 11	0c. City, Town or Loca	ation			10d. Inside City Limits
*		MD Washington	Hagerst	town			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	itry?
th the Maryland 23a or 28a-f sho notified at once.		2019 Day Road		21740		U.S.A.	
or items	Funeral		If No	/as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,
ırs afte ural",	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates;  15. Decedent's Education (Specify only highest grade complete.		Yes 2 No specify: ent's Usual Occupation (Give kind of	work done	Specify: Wh	ite ndustry
72 hou n "nat al Exa	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+	during	most of working life. DO NDT use ret	ired)		ŕ
5-0036 led within 7 Hygiene. I other than the Medica	mpl	6	Care	Giver		Health C	are
Filed w Hygic d othe		17. Father's Name (First, Middle, Last)		18.Mother's Name		laiden Surname)	
2121 uld be fi Mental J marked c event,	o Be	Leslie Alfred Schetrompf 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	Edna B		Custer ber. City or Town. State	Zip Code)
MD ; da 2 shot lith and 1 is 1 and 1		Stacey Knox / Daughter		9 Day Road, Hager			
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mennal Hygiene.  Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	20b. Place of Dispo	osition (Name of cemetery,	Date	20c. Location - City or	Town, State
Pages nent o ant: I		4 Donation 5 Other Specify:		en Cemetery 8/2	0/2012	Hagerstow	n, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If ite		21. Signature of Funeral Service Lice see	7561.	Name and Address of Facility R	est Have	en Funeral	Chapel
Physician	,	23a. Part I. Enter the disease, or complications that caused th	ne death. Do not enter	601 Pennsylvania	Ave., Ha	agerstown,	MD 21742 Approximate Interval
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries volume to (or as a consequence)	vith Complication				Between Onset and Death
		Sequentially list conditions, b	,				
	iner	if any, leading to immediate Due to (or as a conseq cause. Enter Underlying Cause	uence of):				
760, ficate be executed g physician and the burial - transit	I Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a conseq d	uence of):				
760, icate be executed physician and the burial - transi	Medical	UNPENDED AMENDED					
that the death certificate be need by the attending physici detached for use as the burn	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome 1 Live birth 4  Pregnant at tirdeath 9 Ulskoown	2 F	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month	) Day Year
the der	Phy	Part II. Other significant conditions contributing to death t	out not resulting in the	e underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
es sig	ed by					2 No 3 Prob	
Division of Vital Records, P.O. Box 68 within 24 hours after death certifuling 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed				24a. Was a autops perform	sy prior to o	topsy findings available completion of cause of
tal F tian: certific ector, 1	Be C	25. Was case referred to medical examiner?		26.Place of Death (Check			
f Vit Physic er this ral dire	2	examiner? 1 V Yes 2 No  27. Manner of Death  Absolute: 1 Inpatient 28a. Date of Injury				Residence 6 Other ow injury occurred	:
sion o vitending death. ctor: Afte	Certification:	1 Natural 5 Pending Mar 24, 2012  ✓ Accident Investigation	1255 hrs	1 Yes 2 ✔ No	Passenger a	uto auto collision	I.B. da Market O'the
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Sertific	Suicide Could not be determined (Specify)		eet, factory, office building, etc.	or Town, St	treet and Number or Ru ate) ad at Little Antietam F	rai Route Number, City Road, Smithsburg, MD
To the Hos within 24 ho To the Fun completely	Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner on the basis of examiner of paner states.					
	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		' // /(	$\sim$	O.C.M.E.		August 16, 2012	
OCME		30. Name and address of person who completed cause of dea Mary G. Ripple MD. Deputy Chief Medica		00 W. Baltimore Street, Balti	more, MD 21	223	
		31. Date filed (Month)	Signature				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ August 16, 2012 5:27 PM DORIS EILEEN BOWERS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 South Vermont Street Washington Williamsport 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days 220-18-3156 1 🗆 M 2 🕇 F Director 85 Sept. 30,1926 Maryland Usual Residence of Decedent 28a-f show 10a. State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5 South Vermont Street 21795 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛂 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: "natural", Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (14 or 5+) Cook Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Ethel Knode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Stockslager (Daughter) 640 Summit Avenue Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park Aug. 21, 2012 Williamsport, MD 4 Donation 5 Other (Specify) of Funer S 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
I year Immediate Cause (Final Physician/ Ovarian Cancer disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease Or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of Type 2 Diabetes 24a. Was an has autopsy page perform death? Congestive Heart Failure certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🔀 No Hospital Other: 1 Yes 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work?
1 Yes 2 No 5 Pending Investigation after death Accident 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number -2012 00051282 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Samue

Williamsport

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMONTH UST Day 11 2012 ROBERT BERGEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BACIMORE WACHINGTON MESIZAL AMNE CIEN BURNIE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth Funeral Months Days (Month, Day, Year) 400-18-2894 Director 1 ÅM 2 □ F 90 9/2/1921 MARYLAND Usual Residence of Decedent 28a-f show of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND ANNE ARUNDEL **GAMBRILLS** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21054 UNITED STATES 730 MD ROUTE 3 SOUTH 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates. 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE Completed 3 

Wildowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 COMPUTER SCIENTIST **DEFENSE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROBERT BERGEN LULA BOWLES should be Department of Health and Me Important: If item 27 is mark any injury or other traumating Once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 TIMBER WOODS COURT, GAMBRILLS, MD 21054 VIVIAN TRIBETT/FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEAKE CREMATION CENTER 1 Burial 2 XCremation 3 Removal from State STEVENSVILLE, MD 4 Donation 5 Other (Specify) 8/14/2012 e and Address of Facility ASTING TRIBUTES BY FELLOWS NBEIN & NEWNAM CREMATION & FUNERAL CARE BESTGATE ROAD ANNAPOLIS, MD 21401 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due te Examiner Sequentially list conditions, leave leave underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 1 Yes 2 No 2 🗆 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OX Harpiras 32. Registrar's Signature State AUG T4 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BUCK 8 1150 DSA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Linthicum Anne Arundel Tate Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 241-44-5913 Days Hours Min. (Month, Day, Year) Director 1 🗆 M 2 🕏 F 87 12/09/1924 Jamaica Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 12 Riverview Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify. Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CO-Owner Specialty Cakes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Asaad Nicholas Birbari Nabiha Haddad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 805 Petinot Place Stevensville, MD 21666 Gavin Thomas Buck 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Atlantic Crematory Glen Burnie, MD 08/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility 12 Ridgely Ave Annapolis,MD 21401 Jak Hardesty Funeral Home P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician ARKINSON disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 17716 examiner? HOSPICE Decify) HOUS Other: 4 Nursing Home 5 Residence 2 🗔 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 06-2011

State

31 Date filed (Month

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who completed cause of death (Item 23a) (Type, Prin

egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9:06 PM August Millicent Bradler 2012 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nu Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X F 79 March 19, 1933 220-28-0086 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No Sussex Delmar 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A. 36807 Bi-State Blvd. 19940 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo 1 Tyes 2 No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) switchboard operator telephone company 12 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Wesley H. Young Mildred H. Propst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (husband) 19940 Kenneth Ray Bradley, Jr. 36807 Bi-State Blvd. Delmar, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8-15-2012 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Andrews Episcopal Cemetery Princess Anne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home short ( 2 mol 13 East Grove Street 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Delmar, DE Approximate Interval Between Onset and Death immediate Cause (Final Endorascular Lymphoma with netastass to brain Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, I any course of infractions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 TYes 2 No 3 Probably 4 Unknown 24a. Was an

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygls Important; if tiem 2.7 is marked any injury or other 2.7. Physician **⊮**Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

or 28a-f show notified at

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al Hyglene, I other than '

Examiner must be 23a

Medical

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Director

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transi and physician the use as t attending signed by the at page 2 should peen certificate has this funeral After t hours after death. filled in by the

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician;

or Attending

To the Hospital o within 24 hours af To the Funeral DI

Examiner Physician/Medical \$ Completed Be ၉ Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

> 1 ☐ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Tyes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

4 Homicide

(check only one)

30. N we and add

Accident

5 Pending investigation 6 Could not be determined

erson who

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 XInpatient

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 28c. Injury at Work? Injury

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f, Location (Street and Number or Rural Route Number,

4940 Eastern Avenue, Baltimore, MD, 21224

28d. Describe how injury occurred

City or Town, State)

29b. Signature and the of certifie

29c. License number

29d. Date signed (Month. Day, Year)

Michelle 31. Date filed (Month, Day, Year)

AUG 14 2012

MD harp 32. Registrar's Signature back

pleted cause of eath (Item 23a) (Type, Print)

State Registrar

Medical

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thomas Edward Ballard 08 2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL SDC1364/1 HICOMICO ICAL If Under 1 Year If Under 24 Hrs. cial Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Min Director 1**X** M 2 □ F 214-36-7459 70 1 - 22 - 1942MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 734 Camden Avenue 21826 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc φ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Spe Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 end 2 should be filed within 72 l of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Worcester County Maintenance Board of Ed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Artie H. Ballard Elizabeth Wallop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul's Rd, Stockton, MD 21864 Debbie Townsend/Daughter st. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of LLC cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 e Department of H Important: If ite any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Direct Cremation, 8-10-2012 Dover, DE 4 Donation 5 Other (Specify) 1. Signature Funeral Service Licensee 22. Name and Address of Facility 17 W. Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final SLS Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a thed for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🖾 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 8/3/12 anl D73353 31C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAlisbury, Md. 21801 SAVANTHY PATAPARIA 100 E. CARROLL St. 31. Date filed (Month, Day, Year) State Registrar's Signa 08 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bradley Mary Α. Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Scilis bury Examiner 4c. County of Death Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) **Director** 214-34-8890 1 🗌 M 2 🕱 F 11/03/1937 Maryland 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evaniner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Delmar Delaware Sussex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 19940 101 Delaware Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give 1 Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Chatman Page 1 and 2 should be John Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once. Teresa Hoppes/Daughter 1-06 New York Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Allen Cemetery 8/3/2012 Allen, MD 21. Signature of Funeral Service Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disea e, or complications that aused List only one cause on e. ch line aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cau Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ MR Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical **Hospital or Attending Physician**: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2/ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2. No |@ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗀 No A Natural 2 Accident
3 Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cestifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 3 21802 10 50 P 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Pl line b-c, per md 8930 8/29/12 trt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27683 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 2012 1433 M Robert Allen Carner 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-Regional Medical Center Cumberlana 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth Funeral Hours Man 7, 1927 722-12-3314 **Director** 1 🛚 M 2 🗆 F 85 Usual Residence of Decedent 28a-f show 10a. State 10b. Count notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21502 USA 620 Elwood Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give WWI 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WWII 3 X Widowed 4 Divorced Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Military Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Helen N. Osbourne Shelton Luther Carner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 2 Box 208 Ridgeley WV 26753 Nancy White friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State Scarpelli Funeral Home, P.A. 8/3/2012 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) Signat re of Funeral Service Licensee 22. Name and carpein Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ andia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARDIOVASCULAR DISEASE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Duc to for as a consequence of the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed ARTERIOSCLEROSIS and that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year 1 ☐ Yes ∠ ₩ 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 🗹 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the f 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific DOG 39811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 Willowbrook Rd. Cumperland, MD 2150 State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month & Physician/ Year 307M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROGIONAL HICOMICO HENINSULA 3AL136414 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Days Hours Min. Director 215-38-0380 1 - M 2 X F 70 Oct 24, 1941 MD Usual Residence of Decedent il Hygiene. I other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notifled at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Wicomico Ouantico MD 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 21856 USA 25928 Nanticoke Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify: Black Specify: 3 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Education Food Service Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F þe William H. Moore Ina Mae Cottman permit. Page 1 and 2 should t Department of Health and Me Important: If Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Copeland/husband 25928 Nanticoke Road, Quantico, MD 21856 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill
Memory Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 8/11/2012 Hebron, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA
1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on which line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury onas a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Day Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed ometrial 8troma Sarcoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending 2 Accident Investigation 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13465. Division 8+ Suite 103 Salisbury AD 21804 stamily Medicine Delmana Internal 31. Date filed (Month, Day, Year, State 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Gladys Lorraine Christy-Dix 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HILOMICO REGIONAL SAUISBULA TONIN SULD Center Social Security Number 6. Sex 1 Year If Under 24 Hrs Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 220-84-7866 1 □ M 2 🛣 F B-13-1966 MD 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Numbe Of. Zip Code 10g. Citizen of What Country? 236 Dove Street USA 21804 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Spec B: lack Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry t grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Shore-Up, Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gladys M. Christy <u>William H. Horsev</u> 1 and 2 should to the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr <u>Kimberly Abbott/Sister</u> 06 Maryland Ave, Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, 8-13-2012 Dover, DE 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepais Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? signed by the a 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably Winknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? page 2 performed No death? 1 ☐ Yes S No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes Other: ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 31 063199 address of person who completed cause of death (Item 23a) (Type, Print) 34. Date filed (Month, Day, Year)

Registrar

12-05699 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 27686 Grace William & Carlson State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 31, 2012 Medical Examiner Williams Carlson 1054 hrs Grace 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 64087 Willing Drive Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Director 217-30-9223 comaryland 1 M 2 X F 05/31/1935 Yrs 77 Usual Residence of Decedent 10d. Inside City Limits iny 10c. City, Town or Location 10b. County 28a-f show 1 Yes 2 X No Wicomico Salisbury Maryland hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6408 Willing Drive 21801 USA Was Decedent of Hispanic Origin? ( Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, Armed Forces? White, etc. Never Married 2 Married 2 X No Yes If Yes, Give Year 1 Yes 2 X No specify: 3 X Widowed 4 Divorced Specify: White Š 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Petent of Health and Mental Hygiene.

Int: If item 27 is marked other than "1 Baltimore, MD 21215-0036 Education Teacher 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Louise Taylor Daniel Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tment of Health and Merant: If item 27 is may or other traumatic ev 2018 Hopewood Dr., Falls Church, VA 22043 Kristina C. Cook/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8/4/2012 Salisbury, MD 4 Donation 5 Other Specify: Shad Point Cemetery gnature of Funeral Se <sup>22, Name and Address of Facility</sup> Holloway Funeral Home Professional Association hompson Part I. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 21804 Approximate Interva **Physician** Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and tran. Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide

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State

Registrar

Sa

29b. Signature and title of certifier

Exemuli

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner

and manner stated.

32. Registrar's Signature

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

August 1, 2012

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27687 State Registrar Reg. No [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Deavers 2012 1:10 Franklin August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16157 Spade Road Hagerstown Washington If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 220-18-2544 1 M 2 - F 88 May 9, 1924 Maryland ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDWashington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 16157 Spade Road 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chief of Right Away State Highway Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Allen Deavers Maude Rockwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Y. Rotz / Daughter 16157 Spade Road, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spe Rest Haven Cemetery 8/18/2012 Hagerstown, Maryland of Funeral Service Lic 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Onset and Death Physician/ S disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and reley filled in by the funerial director, page 2 should be detached for use as the Durial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an icate has. autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other:
4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 24 hor To the Fune completely f

of death (Item 23a) (Type, Print)

11110 Medical Campus Rd

29d. Date signed (Month, Day, Year)

Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Number Frantitioner: To the basis of my browning State occurred at the time, date and place, and one to the cause(s) and manner stated

120055994

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 27688 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Doret DIXON 23:15PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mongtomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Rinth **Funeral** Min. (Month, Day, Year) 098-48-8160 Director 1 🗆 M 2 🗶 F 76 18, 1935 Damaica Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1XXX Yes 2 ☐ No Waldorf Marvland Charles 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20603 8804 Cottongrass Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Black 3 X Widowed 4 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12th. R.R. Browker Publisher Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Ricketts James Campbell should to and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 8804 Cottongrass St. Waldorf, MD. 20603 Garcia Buckley/ Daughter Baltimore, 20c. Location - City or Town, State
Long Island 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 17, 2012 New York Nassau Knolls Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 20601 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line SEPSIS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical GEART FAILURE Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury KIDNEY Exami HORONIC nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ρ Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by EMBOL MONAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2<sup>r</sup>☐ No 24a Was an page 2 s has autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5  $\square$  Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier Warnin, 3/101

State

Registrar

DHMH 17 Rev 06-201

SHAHYD SHAMIM

G 1 4 2012

31. Date filed (Mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAHYD SAAWIM, WASHINGTON ADVENTST WSDITAL TAKOMA PARK

MD-20012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia	n/	Decedent's Name     MILD	, ,	GRAY		1	DREW					2. Date of D Month AUGUST		Day II 2	2012	3. Time of Death	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1  Never Marri 3  Widowed	ied 2 🗆 Ma	12. Was Decriping Armed Formula 1 ☐ Yes	edent Evorces? 2 X N	er in U.S		Was Decedor If Yes, speci	fy Cubai	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	-		k, White,		
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filed wall Hyg	Be c	17. Father's Name (f	First, Middle,	-						18. Moth	ner's Nam	e (First, Middle	, Maide	en Surname,	)		
uld be Ment narke natic e	P.	MITCHEI		GRAY			Т				ONA		MAR				
2 shouth and the and traum		19a. Informant's Na					1	_				Route Numb	-			ode) , MD 2181	3
1 and f Heal item 2		20a. Method of Disp	oosition				lace of Dispe	osition (Nam	e of	- :		Date	T	Location -			
Page ment o ant: If ury or		1 ☐ Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal from Specify)	n State			matory or ot Y OF D			8/13	/12	DI	ELMAR,	DEL	AWARE	
permit. Departr Import. any inj.		21. Signature of Fun	neral/Service	Licenspe				2. Name and			-	ME, SE	LBY	VILLE.	DE.	19975	
		23a. Part 1. Enter the	the disease, o	or complications that	caused f	the death								•		Approximate	
Physician/ Medical		Immediate Cause ( disease or condition resulting in death)	(Final	a. 141	79	Cau	nce T	•								Interval Between Onset and Death	_
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an an	<u></u>	resulting in death) l	Last	Due to	(or as a	consequ	ence of):										
rtificate ing phy e as th	Med	IF FEMALE;															
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medic	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ₹ 9 ☐ Unknown	months?	23c. If yes, ou 1 ☐ Live 4 ☐ Preç 9 ☐ Unk	Birth 2 gnant at	Fetal	I death 3	Ectopic p Other (sp		у				23d. Date Mor		ery Day Year	
that the ned by e detac	by Pr	Part II. Other signif	ficant conditi	ons contributing to o	death bu	t not resu	ulting in the	underlying c	ause giv	en in Part	: L	23e. Did	tobacc	o use contri	bute to th	e cause of death?	
equires en sig ould b	ted											1/2	Yes	2 🗌 No	3 🗌 Prob	oably 4 🗆 Unknov	vn
<b>sician:</b> The law re certificate has be lirector, page 2 sh	Completed		-										opsy ormed	? p	rior to co eath?	osy findings availabl mpletion of cause of	e
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nysici lis cer l direc	To E	examiner? 1 Yes 2	<b>1</b> No	Hospital:	] Inpatier	nt 2 🗆 I	ER/Outpatie	nt 3 🗆 DO	A Othe	er: 4 🗆 N	lursing Ho	me 5 Res	idence	6 ☐ Othe	r (Specify	)	
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tal or Atters after des al Directoled in by the		3 ☐ Suicide 4 ☐ Homicide	6 Could detern	nined 28e. Place		y - At hoi (Specify)		reet, factory,	office			28f. Location ( City or To			r or Rural	Route Number,	
he Hospit in 24 hour he Funera pleted fill	Medical	(Check 2	☐ Medical	g Physician: To the b Examiner: On the ba g Nurse Practioner:	sis of exa	amination	and/or inves	stigation, in n	ny opinio	n, death o	ccurred at	the time, date	and pla	ace, and due	to the cau	use(s) and manner sta	ated.
North Com		29b. Signature and	title of certifie	er						number	11-7			Date signed			
		I THES	25	Milin	_				100	66	162		4	2.17	1 4	-	
STC		Jettry	R Sc	who completed cause heirer Q	se of dea	iOS)	23a) (Type, I	Print)	KK	12	Barli	'n my	SC	1181			
Stat Registra		31. Date filed (Month	h, Day, Year)	2012	Registrar	's Signa	ure de Ca	Med						•			

		For State Registrar	Plea	_	-			d / Depa		nt of H	lealth		Mental Hy		е	ole.	07	600
Physicia Medic		Decedent's Name     Donn			Davie	s							2. Date of De Month	ath	201	ear	3: Time	or Death
Examin		4a. Facility Name (if	Rogi	ONAL		lical		nter		50	Location	114		40	c. County of	Death	ios	
Funeral Director		5. Social Security No. 309–26–58 Usual Residence of	386	6. Sex	1 2 <b>X</b> ) F		(In yrs. Ia 34	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 06/07/]	ay, Year)	:	Count		or Foreign
Maryland Ba-f show	rector	10a. State Maryland	10b. County	mico			10c. City	, Town or Loc								1		City Limits
s 23a or 2	Funeral Director	10e. Street and Nun 9006 E	nber Executi	ve Cl	lub D	rive	)		10f. Zip	Code 2187	5			10g. C	itizen of Wh	at Coun	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marri 3 🙀 Widowed		ried	Was Dece Armed Fo 1  Yes If Yes, Giv Year or Da	rces? 2 <b>X</b> N		. 11	Yes, spec	cify Cuba		n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e		
rithin 72 hour lene. r than "natu	Completed	(Spe	15. Decede ecify only highe ondary (0-12)	est grade o			+)	life. Do		rk done d e retired)	ation luring mos	t of work	ing		Kind of Busi		•	
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and 2 shou Health and em 27 is m ther traum		19a. Informant's Na Amy Tarr 20a. Method of Disp	/Daugh		Print)		Jook D		Col	ona		Pocc	al Route Number	ity,	MD 2	1851		
nit. Page 1 artment of i ortant: If it injury or o		1 Bunal 2 4 Donation	X Cremation 5 ☐ Other (\$	Specify)	noval from	State	Ce	emetery, cren isbury	cren	nther place	y	8/9/:	Date 2012	Sa]	Location - C	y, 1	4D	
permit Depar Impor any in	_	23a. Part 1. Enter t	the disease, or	complicat	tions that of	caused	the death		OI St	1 WOL	1111	Rd.,	ome Pro Salisb or respiratory as	ury	sional , MD 2	As: 1804	SOCÍA 4 Approxim	
Physician/ Medical Examiner		shock, or hear Immediate Cause ( disease or condition resulting in death)	(Final	only one ca	0	PI	consequ						1	<i>(</i> :	.,	+	Interval B Onset and	
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ate be executed physician and the burial-transit	Sal	that initiated events resulting in death) l		d	Due to	(or as a	consequ	ence of):										_
To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23c.	If yes, out 1  Live 4  Preg 9  Unkr	Birth 2 nant at	Peta	I death 3	Ectopic   Other (sp		у				23d. Date Month		ery Day	Year
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The law rec ate has bee page 2 sho	Completed												24a. Was auto perfe 1 \( \sum \text{Yes} \)	psy ormed2	pric	or to cor ath?	osy finding npletion of 2  No	s available cause of
sician: certific director,	To Be	25. Was case referre examiner?	ed to medical	Hosp	oital:	Impatio	- 2 D	ER/Outpatier	• a 🗆 D		er:		k only one)	-1	a 🗆 ou	0		
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vital or Attures after de ral Directo	al Certi	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	nined	buildi	ng, etc.	(Specify)						28f. Location ( City or Tou	wn, State	e)			nber,
the Hosp thin 24 hot the Fune ompletely fi	Medical	(Check 2	Medical I	Examiner: Nurse Pr	On the bas	sis of ex	amination	and/or invest	igation, in death occ	my opinio	n, death o	ccurred a	nd due to the c t the time, date a ace, and due to	and plac the caus	e, and due to	the cau	ise(s) and ritated.	nanner stated.
P ≥ P 8	4	30. Name and addre	6	س	pleted caus	e of de	ath (Itam	23a)/Time F				4	r. SAU				20/2	
410		M/19 31. Date filed (Mont	10/41	M-1	FARY	1	B4160	als, M	1.0.	100 E	CAN	W/ 5	T. SAL	15641	y Mo			
Stat		A	th, Day, Year)	2012	12	egistrar	's Signat	1º ha	Red									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 07 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CONTE NICOMICO YININ34LA REGIONAL SALISBURG Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 240-28-0928 Director 1 🗆 M 2 🔼 MP 27-1932 10b. County 10c. City, Town or Location with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Pes 2 No MID LCOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21814 death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than /Secondary (0-12) College (1-4 or 5+) Seafood Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) a GBERT DORMAN permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of SOHNSON Mitchel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20970 dd schod st Blualleims BALON I EL Oa. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cernetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) 3Alseury erementan any inj 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CrtenTessid & BURLIE, MD 21814 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Exami anding physician and use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use es the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No q 🗌 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death?

1 Yes 2 No autopsy To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident
3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 0 6 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $20\,1\,2$ For State Registrar Certificate of Death 2. Date of Death Physician/ 2012 12:30 A M August 0 Medical acility Name (in not institution, give s **Examiner** Markow Health toma polis me Age (In yrs. last birthday) 85 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 🔀 F ours 220-16-5891 **Director** Maryland 03/21/1927 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any onee. 10c. City, Town or Location 10a. State Director 1 Yes 2 No Annapolis Anne Arundel |Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21401 963 Marconi Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name *(First, Middle, Maiden Surname)* **Assunta Prat**t 17. Father's Name (First, Middle, Last) Carlo Cardaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1963 Marconi Circle, Annapolis, Maryland 21401 Raymond Foley/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/14/2012 Davidsonville, Maryland Donation 5 Other (Specify) akemont Memorial Gardens 22. Name and Address of Facility George P. Kalas Funeral Home al Se vice Licensee 21. Signa 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Afacroschere 12 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 L 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person leu Brunie Diana No

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary	land / Depa	artment of I	Health and Death	l Mental Hyg	giene 201	2 27693
	Physicia	ın/	Decedent's Name (First, Middle, Last		<u> </u>	incate of i	Jean	2. Date of Dea	th	3. Time of Death
	Physicia Medic	cal	GLORIA B.  4a. Facility Name (if not institution, give		ERS			August	6 201	
العبدر	Examin	ier	CATERED LIVING OF		3	4b. City, Town, o	N PINES	ath	4c. County of E	Death CESTER
	Funeral Director		223-32-6303	ex	yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		9. 1922 V	Birthplace (State or Foreign IRGINIA
	and show dat	ğ	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	e Mary r 28a-f notifie	Direc	MARYLAND WORCES  10e. Street and Number	TER	OCEAN					1 <b>X</b> Yes 2 □ No
	with th	Funeral Director	1135 OCEAN PARKWA	Y		10f. Zip Code	811		10g. Citizen of Wha <b>USA</b>	t Country?
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	lt	Vas Decedent of H	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
2-00	hours natura dical E	Completed	15. Decedent's E	Year or Dates.	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busine	WHITE ess Industry
121	thin 73 ane. than ne Me	Somp	(Specify only highest gn Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	kind of work done of NOT use retired)		orking		
Maryland 21215-0036	ed H	Be	17. Father's Name (First, Middle, Last)			IOMEMAKER		ame (First, Middle, M	OWN H	OME
rylai	ould be fill de Mental marked matic even	P	WILLIS	BERRY			GRAC		CRADDOCK	
	12 sho Ith an 27 is r trau		19a. Informant's Name/Relationship (T)  CAROL L. SUMMERVI					Rural Route Number,	City or Town, State 21811	, Zip Code)
Baltimore,			20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	Db. Place of Dispo cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - City	y or Town, State
ıltim	교환원들		4 ☐ Donation 5 ☐ Other (Specification of Specification)	y) 0	GREEN HIL	L CEMETE  Name and Addre		7/12	MARTINSBU	RG, WVA
B	permi Depar Impor any in		1 July	Anit	7		-	HOME, SEL	BYVILLE,	DE 19975
t	°		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	olications that caused the ne cause on each line.	death. Do not ente	r the mode of dyin	g, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Ph_sician Medical		disease or condition resulting in death)	a. Due to (or as a cons						0.000 2.10 202.17
H	Examiner	er	Sequentially list conditions,	b. Due to (or as a cons	to the	rive				
	uted id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Depressi	7					
	cate be executed physician and the burial-transit		resulting in death) Last	Due to or as a cons	sequence of):					
3760	ficate k ig phys as the t	Medical	IS SERVICE	d						
Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【★No	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	ÿ		23d. Date of Month	delivery Day Year
0.	at the c d by the letache	Phys	9 Unknown  Part II. Other significant conditions or	9 Unknown	t resulting in the u	nderlying cause giv	en in Part I	220 Did tob	and the contribute	e to the cause of death?
Division of Vital Records, P.O.	uires th n signe ald be c	Completed by	Dementia			,g g		1 🗆 Ye	V	Probably 4 Unknown
corc	aw req as bee 2 shou	nplet			· <u>-</u>			24a. Was ar	24b. Were	autopsy findings available to completion of cause of
II Re	n: The ficate h		25. Was case referred to medical			00 8	10 11 101	perform 1 🗆 Yes 2	ned? death 2 No 1	n? Yes 2 □ No
Vita	hysicia nis cert I directe	To B	examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1  Inpatient 2	P ☐ ER/Outpatien	Oth	ace of Death (Cher: 4  Nursing		ence 6 X Other (S)	pecify) Assisted Livi
n of	ding P h. After th funera		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injury work	/ at	28d. Describe ho		d
/isio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is completed filled in by the funeral director, page 2.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		at home, farm, stre		Tes 2 L No			Rural Route Number,
ă	pital ol ours aft eral Dii filled in		29a. Certifier 1 Certifying Phys	ician: To the best of my kr			data d	City or Town		
	he Hos in 24 he he Fun pleted	Medical	(Check 2 \(\superpressure \) Medical Exami	ner: On the best of my kr ner: On the basis of examina e Practioner: To the best of	ation and/or investi	gation, in my opinic	n, death occurred	at the time, date and	d place, and due to the	he cause(s) and manner stated.
	Vith vith Com		29b. Signature and title of certifier	10		29c. License	number 6722		9d. Date signed (Mo	· · · · · · · · · · · · · · · · · · ·
	2510		30. Name and address of person who c		Item 23a) (Type, Pr			•	8/8/1	_
	J.		Danielle Orr 11	107 Racetra	ck Rd	Berlin	MD 2	1811		
	Stat Registra	e ir	31. Date filed (Month, Day, Year) AUG 09 201	2 32 Registrar's Sig	De Sa	Mar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.pt.1c,25,27,28a-f,per me,g931 9-18-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August DUIS GUNDLING 5:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Hospita Prince Ldurel beorge's -dure Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Min. (Month, Day, Year) 213 24 3089 1 🛣 M 2 🗆 F 83 **Director** Jan 29, 1929 Maryland Usual Residence of Dece or 28a-f show 10b. County 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 9000 Briarcroft Lane Apt 324 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 ¬ Yes 2 □ No
If Yes, Give 1954–1956
Year or Dates. Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Univ of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be fili Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ Louis Gundling Sr. Susie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 E. Willow Branch Lane, St. Augustine Florida 32092 Karen L. Luteran (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Aug 13,2012 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria re of Funeral Service Licenses Signa mo1555 Ferry Road, Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sepsis .Ph.si.i.n/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Kidney Sequentially list conditions, if any least any cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Hip Fracture burial-trar Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 L Fetal uear Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pluods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l performed within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 X Yes မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 🔼 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5  $\square$  Pending subject fell **X**Accident fd 7-26-12 unknown<sup>M</sup> Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number of Rural Route Number, City or Town, State) 9000 Briarcroft Ln. Apt 324 Laurel, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Hospital Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D55861 10. 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X Laurel Regional Hospital Munim, 20707 Laurel, 32 Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 936 2-25-13 vt. State of Maryland Poppartment of Health and Mental Hygiene Reg. N.Z. 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1547M George Francis Gray 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICOMICO REGIONAL MEDICAL SD213644 TONINSULA Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea NOV 18, 1 Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 55 Director  $\frac{216}{64}$ -64-0511 1**X** M 2 □ F 1956 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Delmar Wicomico MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21875 8695 Barbara Ann Way #102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 Specify: Black 1 Tes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic... Computer Human Resources Manager 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barrett A. Gray, Sr. Erma L. Blunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8249 Avalon Blvd., Salisbury, MD 21804 Geraldine Gray Binns/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ty ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 8/06/2012 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PHEUMONIA BILATERNL disease or condition resulting in death) DAYS Medical Due to (or as a consequence of) Examiner DysphagiA DAYS Sequentially list conditions, if any, leading to immediate cause. Ente, Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transi ESOPHAGITIS WEEKS Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical AID YEARS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ STAGE RENAL DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N SARLONA KAPOS 5 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital: Other: 1 Yes 2/2 No 1 2 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 1 Natural 5 Pending work?
1 Yes 2 Accident 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36576 MD 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHLISBURY MD ZIBOY DKS ROMALD 1665 WOODBROOK MO LONVITZ 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 9931 9-11-12 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth Hastings 1555 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Rehabilitation + Nucsing Ctr 5. Social Security Number 6. Sex 7. Age (In yrs. last of thday) Salisburu If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 218-20-7392 Director 1 □ M 2 🕱 F 85 02/01/1927 Maryland 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 200 Civic Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 V Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick H. Godfrey Anna J. Hitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph H. Smith / Cousin 1 and 2 s of Health item 27 530 Riverside Dr., Unit 301, Salisbury, MD 21801 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 8/1/2012 Salisbury, MD Stature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association Monoson Snow Hill Rd., Salisbury, MD 21804 CFSP Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin attending physician and for use as the bunal-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 this certificate To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signa 29d. Date signed (Month, Day, Year) 7-31-12 5 address of person who completed cause of death (Item 23a) (Type, Print) Salisbury P Icholas 200 Dorsdulia 31. Date filed (Month, Day, Year) State Registrar

27697

To the Hoepital o within 24 hours af To the Funerel D

31. Date filed (Month 1)

ARID

29b. Signature and title of certifier

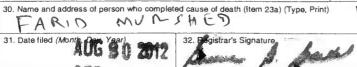
4 Homicide

(Check only one)

29a. Certifier

Medical

State Registrar



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1126

2060336

opal

Hagerstown

29d. Date signed (Month, Day, Year)

114112

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1020 HERRMANN Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 4 Westerly Way Severna Park If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Months Days Hours Director 219-10-0866 1 M 2 X F 86 Nov. 06,1925 Maryland or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 **USA** 4 Westerly Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 XMarried ģ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Year or Dates 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event 90se. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Edna Frances Krumm William Milton West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Lennox Avenue Severna Park, MD 21146 Amy Degenhard / Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of August 10 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State cemetery, crematory or other place) Baltimore, MD Metro Crematory, 2012 INC: 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heat plaintre. List only one cause on as h line. set and Death Immediate Cause (Final SEASE Pnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be emittin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 Residence 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis 3 Certifying Nurse Practitioner: (Check of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified

State

Registrar

Name and address of pe

MICHAEL
31. Date filed (Month, Day, Year)

AUG 13 201

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene FOAMEND#23a per PHY State
Registrar8/14/2012 AXCO HEALTH DEPT CMH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0600M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min (Month, Day, Year) Director 229-88-1772 1 X M 2 D F 56 Yrs. Virginia 2/11/1956 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgewater Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21037 1708 Millstone Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married by X Yes 2 ☐ No Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Equipment Maintenance Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Joan Orr David C. Hash, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1708 Millstone Drive, Edgewater, Maryland 21037 Department of Health ar. Important: If item 27 is any injury or are Patricia A. Hash / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 08/12/2012 | Edgewater, Maryland 4 Donation 5 21. Signature Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD-21037 Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, Due to for as a consecuence of cause. Enter Underlying Cause (Disease or injury Hypercholesterolemia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy perform prior to completion of cause of death? 1 Yes 2 XNo Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient R/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year)

requires that the death certificate be Division of Vital Records, P.O. Box 68760

the attending physician hed for use as the buria as by been signed be should be deta To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I page 2 in by the funeral

and

28a-f shov

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

within 72 hours after death with the Maryland

pe

Maryland 21215-0036

Baltimore,

Medical State Registrar

5 Pending Investigation

6 Could not be

determined

1006007

work?

28c. Injury at

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

00

cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

27. Manner of Death

29a. Certifier

(Check only one)

Natural

Accident 3 Suicide

Certificate:

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year FREDERICK H. HENSCHEN 2012 Medical AUG 2:00A4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE BETHESDA BETHESDA MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 M 2 □ F Days Country) Months Hours Min 047 Director Yrs. IN 66 314-44**-**6238 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a 1 Yes 2 No MD MONTGOMERY **BETHESDA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 6530 DEMOCRACY BLVD. 20817 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ö Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than permit. Page 1 and 2 should be filed within ? Department of Health and Mental Hygiene. Important: If item 27 is marked other thar Elementary/Seconday (0-12) College (1-4 or 5+) HOTEL HOTEL CLERK Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ FRED H. HENSCHEN, SR. MABEL MEYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN DELUCA / FRIEND 17420 RYEFIELD CT., DICKERSON, MD 20842 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 08/14/2012 FREDERICK, MD injury 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility BOX 86 P.O. any BARNESVILLE HILTON FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) month a. PNEUMONTA Medical Due to (or as a consequence of) Examiner LUNG CANCER 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCHIZOPHRENIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? FAILURE TO THRIVE 24a. Was an After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29c. License number 29d, Date signed (Month, Day, Year) AUG. 13, D19609 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN TULI, 10810 DARNESTOWN RD., #202, GAITHERSBURG, MD MD 20878 31. Date filed (Month, Day, Year) AUG 1 4 2012 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JANE HALTAMAN 2012 August 10:50PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING & REHABILITATION CTR. WORCESTER BERLIN Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days MAY 6, 1923 1 🗆 M 2 🗶 F Hours Min Months MARYLAND 89 Director 218-20-5089 Usual Residence of Decedent 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8462 CIRCLE ROAD 21811 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) and Mental Hygiene. HOMEMAKER OWN HOME Jane Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည FRED TAYLOR ELIZABETH TAYLOR permit. Page 1 and 2 shot. Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haltaman, 8462 CIRCLE ROAD, BERLIN, MARYLAND 21811 NANCY J. MEARS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State NEW HOPE CEMETERY Donation 8/11/12 WILLARDS, MARYLAND 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequent of): Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 d. attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Dav Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Records, P.O. ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig Completed 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funeral 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG

Mary Bernal-Clark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FNP-BC,

32 Registrar's Signat

29c. License number

9715 Healthway Dr,

R 131285

29d. Date signed (Month, Day, Year)

Berlin, MD

August 9, 2012

21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Melba B. Hastings Medical 08 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TESINSULA MEDICAL SALISBURG REGIONAL Ceater HICOMICO Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 218-16-6485 88 Yrs. 1 □ M 2 🔀 F Feb. 4, 1924 Delaware 28a-f show 27 is marked other than "natural", or items 23a or 28a-1 sho traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6381 Governor's Square 21801 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Midowed 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th clothing alterations Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Vernon Baker Lillie Mae Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health attem 27 other t Joan LesCallette (Daughter) 6381 Governor's Square Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of I Important: If it eny injury or o' 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) St. Stephens Cem. Aug 5, 2012 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 13 E. Grove Street Short Funeral Home Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit Exam that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 1 Yes 2 9 Unknown Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ or Attending Physician: The law requires Records, as been signal 2 1 Tes 2 No 3 Probably 4 Donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page this certificate death? ar after death.

al Director: After this certificatilled in by the funeral director, pr 2 D No Yes 2 M 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number

1010

Registrar
DHMH 17 Rev 06-2011

State

EASTERN SHORE

eted cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryla		artment of H tificate of D			eg. No. 2012	2 27703
	Physicia		1. Decedent's Name (First, Middle, Las Levin Calvin Hol		<del></del>			2. Date of Deat July	28 20 °2	3. Time of Death 6:00A M
	Medic Examin		4a. Facility Name (if not institution, give Berlin Nursing & I		n Ctr	4b. City, Town, or Berli			4c. County of Dea	ester
-	Funeral		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 28,	g. Bi	rthplace (State or Foreign
	Director		214–28–2978  Usual Residence of Decedent  10a, State 10b, County	82	City, Town or Lo	nation		Apr 28,	1930	10d. Inside City Limits
	Maryland 18a-f sh tified a	recto	MD Worces		erlin	cation				1 🔀 Yes 2 🗆 No
	vith the 7 23a or 2 ist be no	Funeral Director	10e. Street and Number  10020 Germantown	Rd.		10f. Zip Code 2181	1	1	0g. Citizen of What C USA	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.	- 1	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: BI	te, etc.
215-0	יי  <b>an "natu</b> Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give	dent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of worki	ing	16b. Kind of Business	s Industry
in 1212	d withir dygiene ther th nt, the	Be Co	7 17. Father's Name (First, Middle, Last)		Ma	intenance I	Engineer  18. Mother's Name		City Gov	vernment
Levi	d be file Mental H arked o	To E	Lemule Holland	· · · · · · · · · · · · · · · · · · ·			Ida Show			
d, I	d 2 shoul alth and I 27 is m		19a. Informant's Name/Relationship (7) Renate Collick/go			ng Address (Street a Seahawk F			City or Town, State, Z	(ip Code)
Holland, Levin Baltimore, Maryland 21215-0036	Page 1 and ment of Heal tant. If item !		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	b. Place of Dispo cemetery, crer Cal Vary Church	natory or other place Pentecost Cemetery	al 8/3/2	2012	20c. Location - City of Bishopvi	
Ho Balt	permit. Departr Imports any injt		21. Signature I meral Service Licens	Vaise	1 22 I	2. Name and Addres <b>EWIS N. V</b> 618 West	s of Facility Natson Fu Rd. Sal	neral Ho	ome, PA MD 21801	
	Physician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	leath. Do not ent	er the mode of dying	g, such as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death?
	Examiner	<u>.</u>	Sequentially list conditions,	Due to (or as a cons	sequence of):					91115
100	d ansit	Examiner	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury that initiated events	Due to (or as a con	equence of):					cer
0	cate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
876	ificate ng phy as the	Medi	IF FEMALE:							
. Box 68760	law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre  1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	У		23d. Date of d Month	elivery Day Year
ds, P.O	quires that the series of signed by a detail	δ	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause giv	ren in Part I.			to the cause of death?  Probably 4 X Unknown
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed						24a. Was a autops perfor 1  Yes	med? prior to	utopsy findings available completion of cause of
/ital	/sician s certif	To Be	25. Was case referred to medical examiner?  1  Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2	P □ ER/Outpatie	Othe	ace of Death (Checker: 4 X Nursing Ho		ence 6 Other (Spe	acify)
n of \	ding Phy h. After thi funeral	ate: 1	27. Manner of Death  1 X Natural 5 Pending	28a. Date of injury (Month, Day, Year	28b. Time o	f 28c. Injury work	/ at		ow injury occurred	
ivisio	or Attendatter deat Director: in by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined					28f. Location (St City or Town	treet and Number or Fi n, State)	ural Route Number,
۵	Hospital 24 hours Funeral I	Medical	(Check 2 Medical Exam	sician: To the best of my kr iner: On the basis of examin se Practioner; To the best of	ation and/or inves	stigation, in my opinio	on, death occurred a	t the time, date an	nd place, and due to the	e cause(s) and manner stated.
	To the within 7 To the comple	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certify	se Practioner; to the pest of	or my knowleage,	29c. License			29d. Date signed (Mor	oth, Day, Year)
	STE		30. Name and address of person who William Robins	completed cause of death (	Item 23a) (Type, Healt			n, MD	21811	
	Sta Registr		31. Date filed (Month, Day, Year) y 2	012 32. Registrar's Si	gnature	Carbon)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth 1715 AM 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death 1082 An Broadwater hurchtox Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 M 2 TXF 579-20-3994 88 0912874923 WaSMThgton DC **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. ild be filed within 72 hours after death with the Maryland Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Churchton 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1082 Broadwater Point Road 20733 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married by 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural". 3 → Widowed 4 □ Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) mit. Page 1 and 2 should be filed within 73 partment of Health and Mental Hygiene. Portant: If item 27 is marked other than 'injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Insurance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Soresi Gemma Dattore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 Tucker Road Fort Washington, MD 20744 Darlene Soresi Niece 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State Cedar Hill Cemetery 08/15/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uperal Service License 22. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A.Annapolis, MD 21401 Dab 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician Arcin om disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 힏 Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) en aistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

		For	Plea	ase 1							Ensure A ealth and N	•		•	le.	
	-	For State Registrar				,			tificate of			-	Reg. N	1	2	27705
Physician Medica		Decedent's Name	e (First, Middl	e, Last)	Isial	<u>Justi</u>	ice, Jr.					2. Date of De Month 08		lay Y	2012	3. Time of Death $5!/6\rho \text{ M}$
Examine	r	4a. Facility Name (if Hartley Hall				er)			4b. City, Town,	or Lo	Pocomoke		4	c. County of		cester
Funeral Director		5. Social Security N  231-54-	umber	6. Sex		. Age (In	yrs. last birt	thday) Yrs.	If Under 1 Yea Months Days		If Under 24 Hrs. Hours Min.	8. Date of Bir	th 15/19	42	l. Birthp Coun:	place (State or Foreign try) VA
3		Usual Residence of 10a. State				100	c. City, Tow	n or Lo	ention				15/15			0d. Inside City Limits
Marylan 8a-f sh tiffed a	recto	MD		Word	ester	100	c. Oity, Town	II OI LO	cation		Pocomoke					1 X Yes 2 ☐ No
ith the N3a or 2	Funeral Director	10e. Street and Nur							10f. Zip Code		21851		10g. C	Citizen of What	at Coun	•
eath w tems 2 er mus	Fune	1006 Marke	ı sı.,	1	12. Was Deced		in U.S.				anic Origin? (Spe			14. Race -	Americ	an Indian,
rs after death with the Maryland rral", or items 23a or 28a-f show Examiner must be notified at	Completed by	1 ☐ Never Marr 3 ☐ Widowed			1 Yes If Yes, Give Year or Dat	2 🗷 No			Yes 2 🗖 N		Mexican, Puerto Specify:	nicali, etc.)		Black, Specify:	White, 6	etc. Black
72 hou n "natu ledical	nplet	(Spe	15. Decede				16a	(Give I	dent's Usual Occi kind of work done O NOT use retire	e dun	on ning most of work	in <i>g</i>	16b.	Kind of Busi	ness Ind	dustry
within rgiene. rer thau t, the N		Elementary/Sec	onday (0-12)		College (1-4	or 5+)		me. De		,	torial			M	ainte	nance
be filed antal Hy ked ott c event	To Be	17. Father's Name (	First, Middle,	,	siah Justi	e. Sr.				1	8. Mother's Name			n S <i>ur</i> na <i>m</i> e) <b>Drummo</b>	nd	
12 should alth and Me 27 is mar r traumati		19a. Informant's Na		hip <i>(Typ</i> e		, 51.					d Number or Rura wings Mills	al Route Numbe	er, City o			Code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 100 Burial 2 4 Donation	☐ Cremation		Removal from S		cemete	ry, cren	sition (Name of natory or other pl ptist Cemet		1	Date 18/2012	20c.	Location - Ci	-	own, State
permit. Departn Importa any inju		21. Signature	neral Service	Licensee	Co	2			Name and Add		of Facility bles Funera	l Co., Inc.	, Acc	omac, V	A 23	301
		23a. Part 1. Enter t shock, or hea	he disease, or rt failure. List	complication	cations that ca	sed the	death. Do r	not ente	er the mode of dy	ing, s	such as cardiac o	or respiratory a	rrest,		T	Approximate Interval Between
Physician/ Medical Examiner		Immediate Cause ( disease or condition resulting in death)		e a			V 0 M		of G	AL	L BLA	りりもん			+	Onset and Death
	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying	þ	Due to (o	r as a cor	nsequence	of):							+	
ath certificate be executed attending physician and for use as the burial-transit	a	that initiated event resulting in death)	S	c	Due to (o	r as a cor	sequence	of):							+	
ficate b g physi as the t	Medic	15.55141.5		d	l											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23	3c. If yes, outc 1  Live B 4  Pregn 9  Unkno	irth 2 🗌 ant at time	Fetal deat	h 3 🗆 5 🗆	Ectopic pregna Other (specify)	псу				23d. Date of Month		ery Day Year
requires that the de been signed by the should be detached	by Ph	Part II. Other signif	icant conditi	ons con	tributing to de	ath but no	ot resulting	in the u	inderlying cause	given	n in Part I.					ne cause of death?
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The law cate has page 2 s												auto perfe 1  Yes	ormed2	_ dea	ith?	2 No
s certificate h	lo Be	25. Was case referre examiner?  1 Yes 2	ed to medical <b>X</b> No	Н	ospital:	natient	2 □ EB/O	utnatien		No our	e of Death (Check		idence	6 □ Other (	Specify	1
nding Phy tth. : After this e funeral c		27. Manner of Death  1 Natural 2 Accident	5 Pendii		28a. Date o		28b.	Time of injury	28c. Inj	ury at		28d. Describe			Spe Giry,	<del>/</del>
al or Atter s after des I Director d in by th	Certificate;	3 Suicide 4 Homicide	6 Could detern	not be		f Injury - , g, etc. (Sp		arm, stre	eet, factory, office	€		28f. Location ( City or To			or Rural	Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical		Medical I	xamine	er: On the basis	of exami	nation and/o	or invest	tigation, in my opi	nion,	ate and place, an death occurred at ime, date and place	t the time, date	and plac	ce, and due to	the cau	use(s) and manner stated
To the within complete complet		29b. Signature and	title of certifie	Suli	90/n	1)			29 c. Licer		2172			ate signed (A	- 1	Day, Year)
AI		30. Name and addre		who cor			(Item 23a) (	(Type, F	Print) MARKE	T	ST. Pou	OMOKE	C	174	MI)	21851.
State	,	31. Date filed (Monta	h, Day, Year)	5 20	112 32. B	gistrar's S	Signature	4	and I							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13 2012 Eldred Albert Jones August 6:11 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5102 Aireys Road Cambridge Dorchester Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) Days Director 214-42-9521 1 🕱 M 2 🗆 F 67 Yrs Dec. 9, 1944 Maryland Usual Residence of Deceden items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5102 Aireys Road 21613 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. white "natural", Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) waterman seafood event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Wilson Bennett Jones Olive Creighton traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Beverly Jones wife 5102 Aireys Road, Cambridge, MD 21613 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 8/16/12 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between iset and Death Immediate Cause (Final Physician/ estive disease or condition Medical resulting in death) Due to (or a) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the burial-transi and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 Yes 2 N ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury 1 Yes Accident Suicide Investigation Could not be 6 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar Ma

31. Date filed (Month

MD

408

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Reg. No. 20 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EDWIN ROBERTS JOHNSON AUG. 20°1°2 РМ 4:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 23501 OLD HUNDRED ROAD DICKERSON MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Months Days Hours 144-16-8136 0976777917 WASH. **Director** 94 DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director notified MONTGOMERY MD 1 Yes 2 No DICKERSON 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 23501 OLD HUNDRED ROAD 20842 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? , or Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify "natural" 3 ☑ Widowed 4 ☐ Divorced Specify: Completed WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the th FARMER AGRICULTURE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked or traumatic ever permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ WALTER PERRY JOHNSON HAZEL ROBERTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY J. RATTIE/DAUGHTER 23501 OLD HUNDRED RD., DICKERSON, MD 20842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) STAUFFER CREMATORY 08/14/2012 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fun ral S- vice Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has page 2 autopsy performe 1 Yes 2 🗌 No Yes 2 2 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 2 🗹 No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

STEVEN DOLINSKY, 31. Date filed (Month, Day, Year)

(Check

only one)

29b. Signature and title of certifier

911 RUSSELL AVE., MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D20148

GAITHERSBURG.

29d. Date signed (Month, Day, Year)

AUG. 13, 2012

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27708
State of Maryland / Department of Health and Mental Hygiene

		For State Of Registrar	iviaryianu /	•	ificate of D		Wichtairiy	Reg. No.			
Physicia	an/	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of D	
Medi	cal	Lawrence N. Jones  4a. Facility Name (if not institution, give street and numb	nor!		4b. City, Town, or	Location of Dea	August		ty of Death	10:46	аи
Examir	ner	30393 Bottom Creek Dr.	G.,)			sbury			comico		
Funeral		030 40 3300	'. Age (In yrs. last b	oirthday)	If Under 1 Year Months Days	1f Under 24 Hrs Hours Min		th ay, Year)	9. Birth	place (State or F ntry)	Foreign
Director		Usual Residence of Decedent	67	Yrs.			03/31/	1945	Mary.		
yland -f sho	cto	10a, State 10b. County West	10c. City, To						1	10d. Inside City 1  Yes 2	
he Mar or 28a	Director	Virginia Summers  10e. Street and Number	17	alcot	10f. Zip Code			10g. Citizen of	f What Cou		A
with t s 23a nust be	Funeral	Нс 65 Вох 199с			21984			USA	1		
death	y Fur	11. Marital Status 12. Was Deceded Armed Ford 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes		13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (5 n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Ra	ace - Americ ack, White,		
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should be file and Mental is marked of raumatic eve	ľ	Lawrence N. Jones  19a. Informant's Name/Relationship (Type, Print)	1,	19h Mailine	g Address (Street a		V. Boyle		State, Zip	Code)	
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ore, iv		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from		e of Dispos etery, crema	ition (Name of atory or other plac	e)	Date	20c. Location	ı - City or T	own, State	
Daltillort permit. Page 1 a Department of I- Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuperal Service Licensee	Sali	sbury	Cremato	ry ss of Facility_		Salisk	oury,	MD	
any per ga		1/1/56	anl	/ Ho	Name and Addres DILOWAY B DI Snow B	funerál Hill Rd.	Home Pro Salish	otession oury, MD	al As 2180	sociati 4	.on
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tendir death. stor: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At home	e farm stre		Yes 2 □ No	28f. Location	(Street and Nur	nber or Rur	al Route Numbe	er,
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Division of Vital Hecc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physician: To the base 2 Medical Examiner: On the base	is of examination a	nd/or invest	igation, in my opini	on, death occum	ed at the time, date	e and place, and	due to the c	cause(s) and mar	ner stated.
fo the l vithin 2 fo the l	Ž	only one) 3 Certifying Nurse Practitioner  29b. Signature and title of certifier	To the best of my	knowledge,	death occurred at 29c. Licens		nd place, and due to	29d. Date sig			
F > F 0		) M. Kr	mi	) 	Do	0666	109	8-9	'-/2		
LITC		30. Name and address of person who completed cause DR. BILL GAI, 82	se of death (Item 2:		Print) DRIVE	FA	STON 1	MD 21	١٥٥١		
Si	ate	213.3	gistrar's Signatur		111	1-011-					
Regis	trar	AUG 10 2012 4	Later A	1 19	(SALES)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:45PM John Thomas Jones, Jr. 2012 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Niconico at If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs 8 Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Min. **Х** м 2 🗆 ғ Director 214-68-7253 55 11-26-1956 MD permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28e-f shown eny injury or other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 No MD Somerset Princess Anne ۵ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30748 Antioch Avenue 21853 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent L.C. Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specif Black Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housekeeping Eastern Shore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John T. Jones, Sr. Wyoming Tatem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheyenne Scarborough/Siste**t** 1001 Johnson St, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Green Acres Cem 8-11-2012 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Signature # Funeral Service Licensee Funeral Salisbury Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): ending physician and use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the attending phenology IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) detached à signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, cate has been sig Completed 1 Tyes 2 No 3 Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No 1 Yes 2 No director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 8c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ٥/ TERN SIBREDRY 31. Date filed (Month, Day, Year) State AHG 10 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 2012 Alma Jean Krepka 11:38AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5616 Bar Neck Road Cambridge <u>Dorchester</u> **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. (Month, Day, Year) Country 212-30-2769 **Director** 1 M 2 XF 79 12-11-1932 or items 23a or 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Dorchester Cambridge MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5616 Bar Neck Road 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Woodrow Sexton Nora Sizemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Hearn/daughter Cambridge, MD 21613 5616 Bar Neck Rd., Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Spedden Seward 8/17/2012 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High Street Newcomb&Collins FH Cambridge,MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. uch as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final nroni disease or condition Medical resulting in death) Due to (or as a cynsequence of) **Examiner** 19 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, or Attending Physician; The law requires Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2/2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after deam.
al Director; After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Newmie

AUG 14

31. Date filed (Month, Day, Year)

Roger Roland Langlois

2012 27711

	1- For State Registrar			Certii	ficate of	Death			Reg. No.	
Physician. ⊷lical Examine	1. Decedent's	Name (First, Midd Roland	<sub>Langlois</sub>			)		2. Date of De Month August &	Day Yea 3, 2012	2125 nrs
		me (if not institution gh Bridge Ro	on, give street and number ad	per)	4	b. City, Town, or Bowie	Location of D		4c. County of Prince G	eorge's
Funeral Director	5. Social Secu 019–20	-4873	6. Sex 7.	Age (In yrs. last		If Under 1 Yea Months Days		1.4	h 28,1927	9. Birthplace (State or Foreign Country)
Maryland 28s-f show any d at once.	10a. State	10b. County Princ	e Georges		own or Locati	•				10d. Inside City Limits 1 1 Yes 2 No
th the Maryland  23a or 28a-f sho  motified at once al Director	10e. Street an 6600	<sup>d Number</sup> Highbrid	ge Road			10f. Zip Code <b>2072</b> (	0		10g. Citizen of Wh	at Country?
s after death wi ral", nr items siner must be	11. Marital Sta 1 Never I 3 Widow	Married 2 N	Armed Ford    X Yes   Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes   Yes   Yes     Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes   Yes     Yes	2 No No Arcompleted) 1	If Ye	s Decedent of Hises, specify Cubar  Yes 2 X No  Yes 2 Cocupat  Solution of the cocupation of the cocup	specify:	d of work done	No- 14. Race White Specify:	White
5-0036 ed within 72 hourilygiene. inther than "natu he Medical Exan		12			Refrig	<u>eration</u>	Techn 18 Marbara	ician	Self E	mployeed
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MD 21 d 2 should I lth and Mer n 27 is man n mastic ev	-	's Name/Relation Sabdt/D	ship (Type, Print )  aughter		_				umber, City or Town	
or Hea of Hea of Hea of Hea	4 Donatio	2 Cremation 5 Other S		20b. Pla cre <b>Hun</b>	ice of Disposi matory or oth tt Cre	ition (Name of cel ner place) ematory	metery,	Date B/14/2012	20c. Location -	City or Town, State  f, MD
Baltimo permit. Page Department Important: injury nr ott	21. Signature	of Funeral Service	trensee.		22. N	ame and Address	of Facility   Spolis	Robert E. Road Bo	Evans From MD	uneral Home 20715
Physician /Medical Examiner	failure, Li Immediate Ca	ter the disease, o st only one caus- use (Final diseas esulting in death)	Introored aun	shot wound	o not enter th	ne mode of dying,	such as card	iac or respiratory	arrest, shock, or hea	Approximate Interval Between Onset and Death
	Sequentially I		b							
red Insit	cause. Enter (Disease or in events resulti	Underlying Cause jury that initiated ng in death) Last								
executed an and al - transit		DED	d AMENDED							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The law requires that the foreral after death. The rectificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial - transition of Continuation of the Director To Be Completed by Directorian Medical Exitants			the 1 Live birt	nt at time of deat	2 Fe	tal death 3 her (Specify)	Ectopic pr	regnancy	23d. Date of Month	delivery Day Year
P.O. Els that the d		significant cond	itions contributing to c	leath but not resi	ulting in the u	inderlying cause (	given in Part I			bute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaclostification: To Be Commission by					<del></del>			1 ✓ Ye	topsy p	Nere autopsy findings available prior to completion of cause of death?  Yes 2 No
F Vital   Physician: r this certifical director,	25. Was case examiner?		11	patient 2 E	R/Outpatient		r=:	neck only one) lursing Home 5	Residence 6	Other: Scene
fon of beating Pheath.  or: After to the funeral	27. Manner of	Death	28a. Date of (Month, I) Aug 7, 20		8b. Time of I 2100 hrs		iry at Work? Yes 2 ✔ No	Subject el	pe how injury occurrent hot self	ed
Division O' To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	2 Accide 3 Suicide 4 Homic	e 6 Cou	ald not be	of Injury - At hom residence	ne, farm, stree	et, factory, office l	building, etc.	or Town		er or Rural Route Number, City vie, MD
To the Host within 24 hc Thate Fun completely in the Fun completel	zga. Ceruner	Certifying I  Medical Ex	Physician: To the best aminer: On the basis of and manner sta	examination and	, death occur Vor investigat	red at the time, d	ate and place, n, death occur	, and due to the ca red at the time, da	ause(s) and manner ate and place, and d	as stated. due to the cause(s)
To with Cour	29b. Signature	e and title of certif		1/		29c. Licens			29d. Date signo August 9, 2	ed (Month, Day, Year) 2012
Mal		address of perso	n who completed cause Assistant Medica			Baltimore Stre	et, Baltime	ore, MD 2122	3	
Staf	51 D ( 51 )	(Month, Day, Year		istrar's Signature		uks)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-C Per FH G931 9/04/2012 JH State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9: 57 P. M 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate House Anne Arundel Linthicum Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 577 46 8268 Director 1 M 2 XX 78 June 22, 1934 West Virginia Usual Residence of Decedent 10c. City, Town or Location
S Camp Springs 10a. State 10b. County 10d. Inside City Limits the Madical Examiner must be notified at Director Prince George Maryland 28a-f 1 Yes 2 X No 10e. Street and Number 5603 Lansing Drive ŏ 10f. Zip Code 10g. Citizen of What Country? 20748 items 23a Funeral 20 Benton Court United States 20165 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) County Government Program Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Emmett Lusk Zelma Eads 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Poffenbarger Taylor (niece) 20 Benton Court, Sterling, Virginia 20165 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Aug 14, 2012 Clinton, MD ee Crematory 21. Signature of Funeral Seption Lipe  $^{22.\,\text{Name and Address of Facility}}$  Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, MD  $\,$  20735 m00257 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day 4 Pregnant at time of death 9 Unknown Month Year cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed<sup>4</sup> this certificate 2 🗌 No 1 Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital HOSPICE ဂ္ဂ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Foust Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide м 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practitioner: To the bust of my knowledge, death consumed at the time, date and plane, and the to the cause(s) and manner as stated Signature and title of certifier eted cause of death (Item 23a) (Type, Print) Name and address of person Day, Year) IG 1 5 2012 State back Registrar

Please Type or Print in Black Indelible like Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #19a&bPer INF G931 9/24/2012 JH &10c Certificate of Death 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Vivian Lucille Newsome Lucas Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 9. Birthplace (State or Foreign NC ountry) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days DeC 25,1961 Months Hours Min 244 19 3980 Director 50 1 🗌 M 2 🔀 F Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 10d. Inside City Limits Mt. Rainier MD Prince George's 1 X Yes 2 No Mt. Ranier 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 Eastern Avenue 20712 US 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2X Married 72 hours after 21215-0036 1 ☐ Yes 2 № No Specify. Black If Yes, Give Year or Dates marked other than "natural", Specify: 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Acquisition Specialist Federal Covernment Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Wright Ernestine Newsome 19a Informant's Name/Relationship (Type, Print Curtis Lucas/Husband 13613 Eastern Ave. Mr. Rainier Cinar Toyl State Zi20712 Ernestine Sykes / Street Scaboard, NC 27876 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roanoke Salem Bapt. Cem. 8-18-12 Garysburg, NC Signature of Funeral Service Licenses 22. Name and Address of Facility H.D. Pope Funeral Home27870 Bimbelli 520 Smith Church Rd Roanoake Rapids, NC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on nterval Between Immediate Cause (Final RESPIRATOR  $\in$ Onset and Death Physician/ TILURT disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** thock Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ( that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Endometrial Cancer Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Vital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Donatient 2 ER/Outpatient 3 DOA this Division of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined after Hospital 24 hours a Medical 1 Qestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 767 810 012 80-2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCUN Luck ROAD LANhom 700d State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Fucrett William Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death \* PONINSULA RECIONAL NICONICO Centu SALISBURG 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days **Director** 225-47-2355 1 34M 2 1 F 2-10-19 if Health and Mentel Hygiene. Item 27 is merked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Exeminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hecomack Oxom 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4483 23308 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces' Black, White, etc. 1 ☐ Yes 2 DKNo If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Policemen å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mentei ဥ William 1 end 2 should be if Health and Me Item 27 is merk 19a. Informant's Name/Relationship (Type, Print) Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Everett William Juniper . VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Pege 1 Department of Importent: If It any Injury or o Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) -15-2012 4 Donation 5 Other (Specify) Cemete 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chincoteague, VA 2333L Salver Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ettending physician end I for use es the burial-transit Hospital or Attending Physiclen: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 1 Tes 24 hours after death.

Funerel Director: After this certifical etilled in by the funeral director, Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛭 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

13

12-05822 Jack Lowe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 | 277 | 5

		Registrar		Cei	rtifica	ate of	Death				Reg. No	o		
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Funeral	, etc.	Social Security Number	6. Sex	7. Age (In yrs. i	ast birth	ndav)	If Under 1 Y		nder 24Hrs	8. Date of				hplace (State or
Director		216-70-1066	1 X M 2 F	52		Yrs.			ours Min		26/19		Foreign	
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, any		10a. State 10b. County		10c. City,	, Town o	or Locatio	n							10d. Inside City Linits
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er dez	Œ		1 Yes	2 X No		1 .	Yes 2 🗶	No spec	rify:			Specify:	TAT	nite
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ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, William T. Lo	•							(First, Middle Hudsor		n Surname)		
2121; hould be fill and Mental H is marked	To Be	19a. Informant's Name/Relations			19b	. Mailing	Address (St			Rural Route N		City or Town	State	Zip Code)
TMORE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland net of Heath and Mental Hygiene. ant: of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Extinuce must be notified at once	_	Jackie Lowe/Daw												21849
Baltimore, MC permit. Pages 1 and 2 sl Department of Health ar Important: L'item 27 injury or other trauma		20a. Method of Disposition				Dispositi	on (Name of	cemetery,		Date	20c.	. Location -	City or 1	Fown, State
Pages ent of int: L		1 Burial 2 X Cremation 4 Donation 5 Other Sp		on otate		•	Cremat	orv	8/0	9/2012	s	alisbu	ıry,	MD
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr		21. Signature of Funeral Service			/	22. Na	me and Addre	ess of Fac	ility		_			ssociation
			15la	mel		-l 50]	Snow	Hill	.Rd.,	Salis	bury	z, MD	218	04
Physician /Medical	•	23a. Part I. Enter the disease, or failure. List only one cause	on each line. Oxy	ycodone	and	Coca	aine I	ntoxi	icatio	r respiratory a DN	irrest, sh	lock, or heal	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensi	ve Atherosch a consequence of	erotie	Cardio	vascular E	Piceace	7					Death
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58760, rtificate be exe ling physician a	/Me	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pregr	-						23	3d. Date of d		
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Divi	Certification:	_ Julciue Juli	mined (Specify)	Fd: Res	ide	nce				or Town,	State)	211 Wi: .MD.	nte	rbourne Ln.
Hosp 24 hor Fune		(ontour arm)	nysician: To the bes							due to the ca	use(s) aı	nd manner a		
To the Howithin 24 h To the Fu	Medical		miner: On the basis and manner s		nd/or in	vestigatio				t the time, dat				
	Š	29b. Signature and title of certifie	ſ	(	X			nse numb	er					h, Day, Year)
		alul	er	11)	X	)		C.M.E.			Aug	gust 5, 20	J12	
MC		30. Name and address of person Zabiullah Ali, M.D.	who completed caus Assistant Medic			W. Ba	ltimore St	reet. Ba	altimore.	MD 21223	3			
St	ate	31. Date filed (Month, Day Year)	4	egistrar's Signatu			*	,						
Penis		AUG 10 20	112 There	14 /2	1	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>012</u> Physician/ Joan Welton MCCAULEY а М August 3:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Williamsport Williamsport Washington Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Sept. 24 1930 West Virginia Hours 81 Director Yrs. 234-42-9404 Usual Residence of Decedent show : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Williamsport 10e. Street and Number Homewood at Williamsport 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Avenue USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "I life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker 0 Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Esmond Franklin Taylor Lois Gertrude Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra John McCauley - Son 102 Cannon Dr. Newport News, Virginia 23602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Hagerstown Crematory Hagerstown, Maryland Sign to e of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LANCER disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner OBSTRUCTURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of); DEB1474 that the death certificate be executed for use as the burial-transit ON HOSPICE that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month To the Funeral Director: After this certificate has been signed by the a gompleted filled in by the funeral director, page 2 should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Medical Certificate: 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 4656 l 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Umo In MI HACEMIUM

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Dary)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

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egistrar's Signatur

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security N		6. Sex	7. Age (In yrs.				If Under Hours	24 Hrs. Min.	8. Date of Bi		Т	9. Birt	hplace (State or	Foreign
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:30 Рм August 12, 2012 Robert Waring McNitt Sr. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel Annapolis Ginger Cove Health Center 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) (Month, Day, Year) Hours Director 136-32-5757 97 1 🔀 M 2 🗆 F New Jersey 7/29/1915 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 😾 No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 9201 River Crescent Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 38-72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married <u>م</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Navy Admira1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dora Waring Robert J. McNitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 Franklin St, Annapolis, MD 21401 Doug McNitt - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of Important: If it eny injury or o 1 D Burial 2 🔀 Cremation 3 D Removal from State Baltimore Crematory 8/16/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licens 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pulmonary Physician/ disease or condition resulting in death) Medical regurgitation valvular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
28 hours after death.
9 Funeral Director. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical 29a. Certifier To the Hospi within 24 hou To the Funer completely fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 121 cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) AUG 1 4 2012

Hwy, Crofton

			For State of N	Maryland / [				lental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, Last)		Certifica	ate of De	eatri	2. Date of De	Reg. No.		3. Time of Death
	Physicia		Alva Martin Me	easell				Augus		012	6:33 P M
Y	Medic Examin		4a. Facility Name (if not institution, give street and number Frederick Memorial F			ty, Town, or L reder	ocation of Death		4c. County Free	of Death	ck
	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birti	hday) If Un Month	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birthp	lace (State or Foreign
	Director		578-24-7692 1 □ M 2 🖾 F Usual Residence of Decedent	90	Yrs.			March 1		000,	TX
	and show	tor	10a. State 10b. County	10c. City, Town	n or Location					1	0d. Inside City Limits
	Mary 28a-f otifie	irec	MD Frederick	Frede							1 🗌 Yes 2 🙀 No
	ith the	ral	10e. Street and Number			Zip Code 1704			10g. Citizen of USA	What Coun	try?
	eath w	Funeral Director	5901 Quinn Orchard Rd.  11. Marital Status 12. Was Deceder				panic Origin? (Spe , Mexican, Puerto	cify Yes or No-		e - America	an Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1  3 ☑ Widowed 4 ☐ Divorced Year or Dates			pecify Cuban, 2 🖺 No		Rican, etc.)	Blac Specify	ck, White, e	
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d 2	led wi Hygie other ent, tl	Be (	17. Father's Name (First, Middle, Last)		Purch	asing	Agent 18. Mother's Nam	e (First, Middle,	Federal Maiden Surnam		ernment
/lan	d be fi Mental arked artic ev	70	Walter Bird Martin				Mary Ar	ın Coope	er		
/an	shoul		19a. Informant's Name/Relationship (Type, Print)		_		d Number or Rura				
e,	and 2 Health em 27		Linda Phillips/daughter  20a. Method of Disposition		576 Col		m Dr., N	lew Mark	20c. Location		
Baltimore, Maryland	age 1 ent of nt: If ii		1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)		ry, crematory c	r other place)			Frederi	•	
alti	permit. P Departm Importal any injul		21. Signature of Funeral Service Licensee	112.0.		and Address	of FacilityStat				
m	o a m co		MILLANI	W.			ımtown Pi			MD 2	21702
	Physician Medical Examiner		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  a	ed the death. Do n ne. s a consequence of	did	ode or dying,	Ag ti	or respiratory and	est,	<i>h</i>	Approximate Interval Between Onset and Leath
	physician and	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	s a consequence o	1.77.5	01031	,,,	04		<i></i>	
90	ate be physici the bu	edical	d								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		n 2  Fetal death t at time of death	3  Ectop 5  Other					ate of delive	ry Day Year
<u>P</u>	that th	by Ph	Part II. Other significant conditions contributing to death	but not resulting in	n the underlyir	ig cause give	n in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
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Division of Vital Records, P.O.	sician: The law rec certificate has bee Jirector, page 2 sho	Completed							rmed?	prior to cor death?	psy findings available inpletion of cause of
a F	Jing Physician: The land. After this certificate hat funeral director, page	Be C	25. Was case referred to medical examiner?			26. Plac	ce of Death (Check	1 \( \text{Yes} \)	2 <b>/25.</b> NO	1 🗆 Yes	2 L NO
₹	hysic this ce al dire	임	1 ☐ Yes 2 ☐ No Hospital:	atient 2 ER/Ou			4 ☐ Nursing Ho				
n o	ding F h. After	cate	27. Manner of Death  1 Accident  28a. Date of in (Month, E)  28a. Date of in (Month, E)	Day, Year) 285. I	Fime of njury M	28c. Injury a work?	es 2 🗆 No	28d. Describe h	ow injury occurr	red	
ivisio	or Attend after death Director: /	Certificate:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, fai etc. (Specify)			C3 Z	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
Ω	To the Hospital or Attending Physimitin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d	Medical	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of	f examination and/o	or investigation,	in my opinion	, death occurred at	the time, date a	nd place, and du	e to the cau	se(s) and manner stated.
	To the within to the comple	Σ	only one) 3 Certifying Nurse Practitioner: To 29b. Signature and title of certifier	the best of my know		ccurred at the gc. License r			he cause(s) and r 29d. Date signe		
			> Jed & Athen	Jn v	w	D	22K	)	auxu	nt 1	4 20/12
	.6		30. Name and address of person who completed cause of	death (Item 23a) (	Type, Print)		1 , . 1/	1 6	). (Z	21	171705
	62	0	31. Date filed (Month) Day Year A 2017 32. Regis	trar's Signature	-)/1	5 (	rull to	1/1/	L TI	41	uh me
	Stat Registra		AUG 14 2012	sum A.	park	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 10 ay 2012 ear Physician/ Eugene H. Mitchell II 2:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Hours Min. 212-72-9750 Director 1 XM 2 F Yrs. 56 June 22, 1956 Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other then "naturel", or items 23a or 28a-f show traumatic evant, the Medical Evanin minute he multifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Willowdale Drive, Apt.11 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 XDivorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programer IT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eugene H. Mitchell Constance Catherman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitch Mitchell 6945 Golden Valley Court, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 ACremation 3 Removal from State 8/14/2012 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the distance, or complications that is used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is, or heart failure. List only one cause of each line. Approximate Immediate Cause (Final Onset and Death Physician/ Myocardin disease or condition resulting in death) minutes Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physicien and I for use as the burial-transit that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year signed by the at Id be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To tha Funerel Director: After this certification properties of the funeral director, completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ol or Attending F s after death. 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury Work! 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year, Zaidi D43091 8-12-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zaidi MN 801 House Ave. dieed 21701 Toll 31. Date filed (Month, Day 32. Registrar's Signature State Reserva Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Morgan August 9:25a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth (Month, Day, Year) Dec 27 1937 Months Days Director 32 4400 1 € M 2 🗆 F 74 parmit. Page 1 and 2 should ba filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinant must be notified at once. 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1, P Yes 2 No St. Mary's <u>Lexington Park</u> 10f. Zip Code 10g. Citizen of What Country? 21480 Sydney Drive 20653 US 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas C. Morgan Rosemary Holland I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Morgan/wife 21480 Sydney DR. Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State st. George's Cem 4 ☐ Donation 5 ☐ Other (Specify) 8-17-12 Valley Lee, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BRISCOE-TONIC Funeral Home 38675 Brett Way Mechanicsville, MD 20659 23a. P 1 1. Enter the descent or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest such, or heart folium. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1croscievatic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence 🖈 been signed by the attanding physician and should be datached for usa as the burlal-transit daath cartificata ba axecuted that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b complataly filled in by the funeral director, paga 2 si autopsy performed? Yes 2 100 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident Investigation 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08-14-12 D0060100 7 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAYMINA Silmint mo 831 Univerty BU0 31. Date filed (Month, Day, Year) AUG 15 2012 State

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	ase Type or State o	of Marylar						1ental Hy	giene		- 4	
		State Registrar  1. Decedent's Name (First, Middle	- Lost		Cer	tificat	e of D	eath			Reg. No	012	- I-	27722
Physicia Medic		Margaret Milli	on		·					2. Date of Dea August	8 <sup>Day</sup>	2012	9	:18p M
Examin	er	4a. Facility Name (if not institution Genesis Of Wal		mber)			Town, or l	Location of	Death		4c. C	ounty of De		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde		If Under 2	4 Hrs. Min.	8. Date of Birt		9. 6		(State or Foreign
Director		374-07-8229 Usual Residence of Decedent	1 □ M 2 <b>X</b> ) F	103	Yrs.					July 25	,			gton,D.C.
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e Man r 28a- notifie	Director	Maryland Charl 10e. Street and Number	es	Walc	lorf	10f. Zip	- Codo				10. 011-	6 1471 - 4		Y☐ Yes 2 ☐ No
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death items ner mi	Fun	11. Marital Status	12. Was Dec	edent Ever in U. orces?		Vas Dece	dent of His	panic Origin, Mexican,	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		I. Race - Ar Black, Wi		ndian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. In proprant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ Mar 3 🄀 Widowed 4 ☐ Divorced	rried 1  Yes If Yes, Gir Year or D	2 <b>X</b> □ No ve	1	☐ Yes	2No No	Specify:			Sį	pecify: W		:
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknowh	1 🔲 Live	itcome of pregn Birth 2 Per gnant at time of nown	taí death 3 🗌	Ectopic Other (s)		/			23	3d. Date of Month	delivery Day	/ Year
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sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical					26 Pla	ce of Death	(Check	1 Yes	2 2 00		Yes 2	No
nysicia nis cert I direct	To Be	examiner? 1  Yes 2 No	Hospital:	Inpatient 2	BR/Outpatien	t 3 🗆 D	Other	r]	,	me 5 Resid	dence 6	Other (Sr	pecify)	
arth. r: After th	Certificate:		igation	e of injury oth, Day, Year)	28b. Time of injury	M	28c. Injury work? 1 ☐ \		- 1	28d. Describe h	ow injury o	ccurred		
ital or Atter de urs after de ral Directo		3 Suicide 6 Could 4 Homicide detern	nined 28e. Place build	e of Injury - At h ling, etc. (Specii	fy) 					28f. Location (S City or Tow	n, State)			ite Number,
the Hosp nin 24 hou the Fune npletely fi	Medical	(Check Z Medical only one) 3 Certifyin	g Physician: To the l Examiner: On the ba g Nurse Practitione	isis of examination	on and/or invest	igation, in	my opinior	n, death occ	curred at	t the time, date a	ınd place, a	nd due to th	he cause(s	
P S P S P S P S P S P S P S P S P S P S		29b. Signature and title of certifie	two	IC	$\sim$	280	c. License	number )	06	29	29d. Date	signed (Mo	onth, Day,	Year)
BON		30. Name and address of person	who completed cau	ise of death (Iter	m 23a) (Type, P		, D,	W	A	DIR	FN	20	26	0603
Stat Registra		31. Date filed (Month Aug Year)	4 2012 32	Registrar's Signa	ature.	ale	/							

		•	For State Registrar	te of Maryland / Dep <i>Ce</i>	ertificate of L		ientai Hy	Reg. No.	)   2	27723
	Dhysisis		Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Helen Collick Mills				Aug	07	2012	2318 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street a Snow Hill Nursing Hor		4b. City, Town, or Snow Hi	Location of Death			nty of Death <b>Orcest</b>	er
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	) If Under 1 Year	If Under 24 Hrs.	8. Date of Bii (Month, Da			lace (State or Foreign try)
	Director		149-22-7534 <sup>1□ M 2</sup>	94 Yrs.	Months Days	Hours Min.	Feb 3	1918		MD
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation				10	0d. Inside City Limits
	Maryli -f sho ied al	ţo	MD Worcester	Snow Hi	.11					1X Yes 2 □ No
	h the or 28a e notifi	Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Count	try?
	ath wit		4108 Market Street		21863				USA	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 2a or 28a-f show or other traumatic event, it is a fine or other traumatic event, it is a fine or other traumatic event.	by Funeral	1 Never Married 2 Married 1 If Y	is Decedent Ever in U.S. ned Forces?  JYes 2 XNo es, Give ar or Dates:	. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - America Black, White, e ecify: Bla	etc.
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	oleted) (Giv	edent's Usual Occup	during most of work	ing	16b. Kind of	f Business/Ind	dustry
121	within ane. <b>than</b> "	ldm		llege (1-4or 5+)	DO NOT use retired Bus Cont	•		Publ	ic Edu	cation
<u>q</u>	filed 'Hygik THygik Sther ent, II	Be Co	17. Father's Name (First, Middle, Last)		Bus come	18. Mother's Name	e (First, Middle			
/lan	Mental arked o	To B	Walter M. Collick			Dollie H	armon (	Collick		
Maryland 21215-0036	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Type. Pri	,	iling Address (Street					Code)
e,	1 and Health em 27 ther t		Christa Fletcher/grea		Market S		Date		on - City or To	wn, State
	Pa ant:		1 ဩ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	Coolspri	position (Name of ematory or other place Lng UMC Ce	m  8/14/	2012		etree,	
Ball	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee	In I	22. Name and Addre Ewis N. W 1618 West	atson Fun	eral Ho	ome, PA MD 218	301	
		7:	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Carl.	Physician		Immediate Cause (Final disease or condition	Acute Coro.		suffice				Oliset and Death
est.	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1	6 .	/			
		jer	Sequentially list conditions, If any, leading to immediate	Due to (or as a consequence of):						
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c.							
90	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):						
68760,	ficate to physical from the post of the po	edical	d							
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			es, outcome of pregnancy				23d.	Date of delive	ery
Ö.	death le atte	Physician/M	in the past 12 months?		B ☐ Ectopic pregnanc D ☐ Other <i>(specify)</i> _	;y 			Month	Day Year
P. 0.	at the de	Phys	9 ☐ Unknown  Part II. Other significant conditions contributi			on in David	220 Did	tobacco use o	contribute to the	ne cause of death?
ds,	ires tha signed d be det	by	Rhicans toid A	-	underlying cause giv	ell III Fait I.				pably 4 ☐ Unknown
Sor	w require s been si should b	Completed	1				24a. Wa:	s an 24	4b. Were auto	psy findings available
Re	he law te has age 2 s	дшо	70 2 D 1 2	es Mellitus			auto perf	opsy formed?	prior to col death? 1 ∐Yes	mpletion of cause of
ita	ian: T rtificat tor, pa	Be C	25. Was case referred to medical examiner?	es //122/1/265		26. Place of Deat	1 ☐ Yes th (Check only		TLI fes	2 🗆 110
<u>&gt;</u>	hysic his ce Il direc	0	1 Yes 2 No Hospita	1 Inpatient 2 ER/Outpat		4 LIPINUISING HO				fy)
Division of Vital Records,	ding Physician: The h. h. After this certificate h. funeral director, page	ion:	1 ☑ Natural 5 ☐ Pending	a. Date of Injury (Month, Day, Year) 28b. Time Injury	/   Wor	ryat k? lYes 2 □ No	28d. Describe	how injury oc	curred	
Sic	Attend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	e. Place of Injury - At home, farm,		ires z 🗆 No	28f. Location	(Street and No	umber or Run	al Route Number,
<u>≤</u>	al or A s after al Dire	Certification: T	4 Homicide	building, etc. (Specify)			City or To	own, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification that the funeral director. After this confidence of the funeral director.	Medical (	(Check only 2 Medical Examiner: C	: To the best of my knowledge, de on the basis of examination and/or and manner stated.						
	To th within To th compl	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
			Ely de Exert 60	LJews.	Doc	6325 3	7	8-	9-12	
	STO		30. Name and address of person who complet  Linde Expect G:  31. Date filed (Month, Day, Year)  AUG 13 2012	ed cause of death (Item 23a) (Typ	e, Print)	1 1		1.21		F 1 9
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	5 W. Mia, Fe	J 5T. 1	1347	11111111	11 16	000
	Registr		31. Date filed (Month, Day, Year) AUG 13 2012	Course A. A	have					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Henry Northcraft, Jr. August 08 201º2 11:43 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth Hours 1172771955 56 Mary land 233-74-2217 Director Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1809 Glenarm Road 21037 United States Let 1215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature" any injury or other traumatic enterment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates. 1975–82 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ George H. Northcraft, Sr. Virginia Pearl McFarland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly D. Northcraft/Wife 1809 Glenarm Road, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rocky Gap Veterans Cem. 08/13/2012 Flintstone, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner nding physician and use as the burial-transit Due to (or as a consequence of Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medica examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Tes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 10 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one

gistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bertha Ann Harmon Ortiz July 2012 1600 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min. Hours (Month. Day, Year) 214-90-6323 **Director** 1 □ M 2 F 47 Aug 18, 1964 MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Worcester Ocean Pines 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 270 Windjammer Road 21811 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) County Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Board of Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur J. Harmon Bertha R. Milbourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha R. Milbourne/mother 270 Windjammer Rd., Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Curtis UMC Cemetery 18/4/2012 4 Donation 5 Other (Specify) Bishopville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury Due to (or as a surresquence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month signed by the a ld be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မ 1 🗌 Yes Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Peath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Signature and title 1TC Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) AUG 0 6

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea	_				/ Dep		nt of H	lealth			Hygie	2.0	gible.	27726
Physicia		Registrar  1. Decedent's Name	e (First, Middle Lena	,	TARIS	 S		<del>Oe</del> i	lincal	e or L	Calli		2. Date of Monto	of Death		o Year	3. Time of Death 3:55 a M
Medic Examin		4a. Facility Name (if		_				<u>-</u>	1 1	, Town, or Willi					4c. Count	y of Death hingt	•
Funeral Director		5. Social Security No. 216–20–9	716	6. Sex		7. Age (In	-	t birthday) Yrs.		er 1 Year	If Under Hours		,	h, Day, Yi		9. Birthp	place (State or Foreign
Maryland :8a-f show tiffied at	rector	Usual Residence of 10a. State  Maryland	10b. County Washi	ngton		10		Town or Lo					L			1	0d. Inside City Limits 1  Yes 2  No
s 23a or 2 s ust be no	Funeral Director	10e. Street and Nun		rive		•			10f. Zi	p Code 2174	42			10	g. Citizen of <b>U . S</b>	What Cour	itry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status  1  Never Marri 3  Widowed		ried	Was Deced Armed For 1  Yes If Yes, Give Year or Da	rces? 2 X No	in U.S.		If Yes, spe	cify Cuba	n, Mexica	n, Puerto	ecify Yes o Rican, etc	r No- .)		ce - Americ ick, White, e	
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d be filed v Vental Hyg arked othe	To Be	17. Father's Name (#		,							18. Moth	er's Nam	'		iden Surnam ernand	ne)	
nd 2 shoul salth and N n 27 is ma		19a. Informant's Na			,									,	ity or Town, n, Mai	, ,	Code) 1 21742
Page 1 al ment of H tant: If itel lury or oth		20a. Method of Disp 1 X Burial 2 4 Donation	☐ Cremation	3 🗌 Rem	oval from		cen	ce of Dispo netery, crei ar La	matory or o	other place	. i <sup>r</sup>		Date 5 1 12	• 20	c. Location Hager		wn, State , Maryland
permit Depart Impor any in		21. Signature of Fur	neral Service L	icenses	ian			- 1							eral cown,		and 21740
Physician/ Medical		23a. Par . Enter the shock, or hear limmediate Cause (I disease or condition resulting in death)	rt failure. List o Final	complicati only one ca a	use on ead	ch line.	1 :	the					1				Approximate Interval Between Onset and Death
Examiner	ıer	Sequentially list coi		b. –	·	or as a co		14	4/	sert	enzi	on	den				
e e) ciar ouriż	cal Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	rlying injury s	c. –	ì	or as a co		,	ε	•			······································				
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 3 should be detached for use as the total completely filled in by the funeral director, page 3 should be detached for use as the total completely filled in by the funeral director, page 3 should be detached for use as the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months?		If yes, outc 1  Live E 4  Pregr	Birth 2 🗔 nant at tim	Fetal d	leath 3	Ectopic Other (s)		у					ate of delive	ery Day Year
ires that the signed by th	by	g ☐ Unknown Part II. Other signifi	icant condition	ons contrib		eath but no	ot result	ing in the u	ınderlying	cause giv	en in Part	I.		Did toba	N		e cause of death?
The law requate has beer page 2 shou	Completed		sials	etes		nie	Cli	Tus						Was an autopsy performe Yes 2			osy findings available impletion of cause of 2 No
ysician: is certific director,	To Be (	25. Was case referre examiner?  1 \sum Yes 2	ed to medical	Hosp		npatient	2 🗆 <b>E</b> F	R/Outpatie	nt 3 🗆 D	Othe	r b		k only one)	Residenc	ce 6 🗆 Oth	ner (Specify	
anding Ph eath. or: After th	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pendir	g gation	8a. Date o (Monti	of injury h, Day, Ye		3b. Time of injury	M	28c. Injury work	at				injury occur		
ital or Atterins after de al Directo		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ			of Injury - ig, etc. (Sp		e, farm, str	eet, factor	y, office				ion (Stree r Town, S		er or Rural	Route Number,
the Hosp thin 24 hor the Funer mpletely fil	Medical	only one) 3	☐ Medical E	xaminer: (	on the basis	s of exami	ination a	nd/or inves	tigation, in death occ	my opinio curred at th	n, <b>d</b> eath o ne time, da	ccurred at	t the time, o	ate and period to the c	ause(s) and	ue to the cau manner as s	se(s) and manner stated. tated.
O O O		29b, Signature and	title of certifier	Mak	mo	50	1	115	9	c. License $\delta oc$		23	3	290	I. Date signe	(Month, E	2012
5		30. Name and address	entoe	A						742					′	/	
Stat Registra		31. Date filed (Mont	ADG TO	2012	32.	egistrar's S	Signature		2.3	A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9, Day 2012 Katherine Marie Pinkham 7:50 A M Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1617 Knoxville Road Edgewater Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 212-64-0877 Director 1 M 2 X F 59 Yrs. Jan. 14,1953 Washington, D.C. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1617 Knoxville Road USA 21037 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Turf Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edward Pinkham Edna Whitlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Pinkham Autumn Chase Drive Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Edgewater, Maryland 4 Donation 5 Other (Specify) Kalas Crematory 8-20-2012 21. Signature of Funeral Se 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ arond gland disease or condition resulting in death) Cancer Medical Due to (or as a consequence f): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a d be detached f g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 🕅 Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 X No 1 Yes Physician: completely filled in by the funeral director, Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗓 ၉ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) Kanine weing MD Name and address of person who completed cause of death (Item 23a) (Type, Print) leanine werre, MD. #20 Parkway 31. Date filed (Month, Day, Year) AUG 1 3 2012 State Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygien 20 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0727 M rainio Medical 2012 4a. Facility Name if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death HICOMICU Centa MEDICAL **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Days Months Hours (Month, Day, Year) Director 1 □ M 2 👺 F 11-8-1929 28a-f show 27 is marked other than "netural", or items 23a or 28a-f sho traumatic event, the Modical Examinar is ust be in titled at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No ccomack hincoteague 10e. Street and Number 10g. Citizen of What Country? Funeral 0330 3336 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: and Mental Hygiene. is marked other than "netural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 B Palmer hincoteaque injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Importent: If ite any injury or ot 20c. Location - City or Town, State 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-14-2012 4 ☐ Donation 5 ☐ Other (Specify) Taylor Mcm. emperanceville, VA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility VA 23336 tuneral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ordiogen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ate has been signed by the attending physician and pege 2 should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (br as a consequence of): resulting in death) Last Physician/Medical Stoge IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, B B 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes မြ 2 No 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F (arroll 100 31. Date filed (Month, Day, Year) State 32. Registrar's Signatu 13 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year August 12:20 PM Rebecca Wootten Phippin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min Director 217-16-9227 1 □ M 2 🛣 F 10-15-1915 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
• is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 83rd Street 21842 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ڄ 1 Never Married 2 Married Phippin , hebered Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant/Gift Store Treasurer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Wootten Alphonso Gertrude Parsons permit. Page 1 and 2 should Department of Health and M Important: If Item 27 is man any Injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8A 83rd Street, Ocean City, Maryland 21842 Jacqueline P. Webster - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Wicomico Memorial Pk 8-7-2012 Salisbury, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Bounds Funeral Home worker 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physiclan page 2 should be detached for use as the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an After this certificate has autopsy Yes 2 T 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, i 25. Was case referred to nedical Certificate: To Be 26. Place of Death heck only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

AUG 06

2012

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ R Palmer 2012 Engel Marv Medical August 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 401 Gunby Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Days Hours 215-20-0707 Director 1 🗆 M 2 🔀 F 93 11/09/1918 New Jersey Usual Residence of Deceden or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 N No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Items 23a 21804 USA 401 Gunby Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black White etc. 9 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) laryland 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Engel Mary Williams Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1038 Caravan Way, Salisbury, MD 21804 Barbara P. Koontz/Daughter permit. Page 1 and 3 Department of Heali Important: If Item 2 any injury or other timore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔲 Burial 2 🕱 Cremation 3 🗍 Removal from State 8/7/2012 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit ettending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death the page 2 should be detached g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home မှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one Signature 29d. Date signed (Month, Day, Year)

State Registrar

OTC

ND 21802

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State	of Maryland	/ Departme			_	-	2012	27	131
				Registrar  1. Decedent's Name (First, Middle, Last)		Certifica	ale of L	Jeani	2. Date of De		012	3. Time of	
		Physici		William Edward Pit	tman, Sr.				July	2 Day	2012	101	34
	mar.	/Medid Examin		4a. Facility Name (If not institution, give street and		t.		Location of Deat	MA		County of Death		<b>—</b>
•	1			5. Social Security Number 6. Sex	ing Mana		rinc der i Year	ess An			Samo 9. Birth	Place (State of	or Foreign
		Funeral Director		217-42-5511 1X M 2□		Yrs. Month		Hours Min.	8. Date of Bir (Month, Date 2 – 1 4 –	y, Year) 194!	Cou	ntry)	. ,
				Usual Residence of Decedent		Town or Location						10d. Inside Ci	ity Limits
		f shov	ō	10a. State 10b. County	,							1 ⊠Yes	
		the Maryland r 28a-f show	Director	MD Dorchester  10e. Street and Number	Camp	ridge 10f.	Zip Code			10g. Citiz	zen of What Cou	ntry?	
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_		items	Funeral	11. Marital Status 12. Was Arme	Decedent Ever in U.S. d Forces?	13. Was Dec	cedent of Hi pecify Cuba	ispanic Origin? (S In, Mexican, Puer	specify Yes or No to Rican, etc.)	- 1	4. Race - Amer Black, White,		
5	36	ours afte ral", or i	by F	If Voc	es 2□No , Give or Dates: <b>Army</b>	1 □ Yes	2 <b>X</b> No	Specify:			<sup>Spe</sup> ∰lacl	ζ	
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0	ž	and 2 salth a n 27 is	H	William E. Pittman									
30	Baltimore, Maryland	ges 1 t of He if iten or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal f	rom State 20b. Plac	ce of Disposition (A netery, crematory o	Name of or other plac	re)	Date	20c. Lo	cation - City or T	own, State	
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7/30/301	Ba	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other to any injury or other traumatic event, In once.		21. Signature of Funeral Service License		Benni		ss of Facility 91	/ w. 15 lisbury	abe.	D 2180	• 1	
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Z	Box	Hospital or Attending Physician: The law requires that the death certify hours after death.  Funeral Director: After this certificate has been signed by the attending telled in by the funeral director, page 2 should be detached for use and telly filled in by the funeral director, page 2.	Physician/M	in the past 12 months?	Live birth 2  Fetal d Pregnant at time of dea	eath 3  Ectopi	ic pregnancy (specify)	у			Month		Year
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lam	Į.	Physician: this certific al director,	o Be	examiner?	1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 🗆	DOA Oth	ar: e	Home 5 ☐ Res		3 □Other (Spec	cify)	
$\stackrel{\sim}{=}$	0	ding Ph h. After th funeral	Certification: To	27. Manuer of Death 1 Natural 5 Pending 28a.	Date of Injury 2 (Month, Day, Year)	8b. Time of Injury	28c. Injur Work	y at k?	28d. Describe	how injur	y occurred		
5	Sio	ttendi death. tor: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Place of Injury - At hom	M o form street fact		Yes 2□No	28f Location	Street an	d Number or Ru	ral Boute Nur	nher
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		To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Att completely filled in by the fun	SalC	29a. Certifier 1 Certifying Physician: 7 (Check only 2 Medical Examiner: On	o the best of my knowl	edge, death occur	red at the til	me, date and place	ce, and due to the	e cause(s	and manner as	stated.	c)
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		0		30. Name and address of person who completed	cause of death (Item 0	(Type Print)	-	1347094					
	\	14.		30. Name and address of person who completed			1V15	en ste	1- 540	153V	my M	B 218	24
			ate	31. Date filed (Month, Pay, Year) 2012	32. Registrar's Signatur		1						,
		Regist	rar	- 4 - 4016	CONTRACT CO	400000							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ 2012 1216AM Ruark 10 Douglas Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omico the If Under If Under 24 Mrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Hours Min. Director 215-38-0726 1 1 X M 2 □ F 5-14-1941 Maryland 71 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show winjurn or other traumatic event, the Modes Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Salisbury MD Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21804 USA 4099 Meadow Bridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, vas ⊔ecedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No 1959— If Yes, Give Year or Dates. 1965 Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Building Supplies 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Wilson Ruark Dorothy Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4099 Meadow Bridge Road, Salisbury, Maryland 21804 Gayle Ruark Welsh - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Salisbury, Maryland 8-13-2012 Wicomico Memorial Pk.: 4 Donation 5 Other (Specify) Bounds Funeral Home 21. Signature of Fundral Service Licens 22. Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or comp shock, or heart failure. List only or dions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate
Interval Between
Onset and Death
MonTh S Immediate Cause (Final Chronic obstructive rulmonary Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burlal-transit that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumonia 1 Yes 2 No 3 Probably 4 12 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No Hospice 욛 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number #68413 29d. Date signed (Month, Day, Year) Junavole - Sheehan D.O. 08-10-2012 STO 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 1733 Salisbury, MD 21802 IVA 31. Date filed (Month, Day, Year) AUG 13 State 2012 Registrar

DHMH 17 Rev 06-2011

				artment of Health a tificate of Death		eg. No.	27733
ı	Physicia Medi				2. Date of Death August	6, Day 2012 Year	3. Time of Death 6:42 PM
marke.	Examir		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital Center	4b. City, Town, or Location of Clinton	f Death	4c. County of Death Prince Ge	
	Funeral Director		5. Social Security Number 579-86-4487  Usual Residence of Decedent  5. Sex 1	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day, 02/16/1	Year) Coul	nplace (State or Foreign ntry)
	aryland a-f show fied at	Director				1	10d. Inside City Limits 1 ☐ Yes 2 <b>XX</b> No
	rith the Ma 23a or 28 st be noti	ral Dire	10e. Street and Number 13516 Lord Sterling Place	10f. Zip Code 20772	1	0g. Citizen of What Cou USA	
36	s filed within 72 hours after death with the Maryland ital Hygiene. So of their than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 X Never Married 2 Married 1 Yes 2 XXNo	/as Decedent of Hispanic Origi Yes, specify Cuban, Mexican, ☐ Yes 2XX No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White,	
2-00	2 hours a "natural edical Ex	Completed	3 Widowed 4 Divorced Year or Dates.  15. Decedent's Education (Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of	of working	Specify: B	Black Industry
2121	within 7, giene. ner than t, the Me			Service		Maryland Dept. Corre	ections
yland	should be filed and Mental Hy 7 is marked oth raumatic event	To Be		18. Mother Bet	's Name <i>(First, Middle, M</i> ty Mason		
Man	C			g Address (Street and Number 5 Lord Sterlin			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once.		20a. Method of Disposition 20b. Place of Dispos	sition (Name of atory or other place)	Date 2	20c. Location - City or To	own, State
Baltir	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signatur Funeral Sovice Lipensee 22.	Name and Address of Facility 60 Oxon Hill R	George P. K	alas Funera	al Home, P.A
(	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.				Approximate Interval Between Onset and Death
	Examiner	1	Due to (or as a consequence of):  Sequentially list conditions,  b.	nal Disea	isc		
1	cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 Type II E	nality M	lellitus	
260	cate be executed physician and s the burial-transit	edical E	resulting in death) Last  Due to (or as a consequence of):  d.				
Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  the Funeral Director. After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
Division of Vital Records, P.O.	es that th signed by I be detac	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to the	
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of Vit	Physici r this cer eral direc	욘	examiner? 1	Othor	sing Home 5 Residen		)
sion	ttending death. :tor: Afte / the fune	Certificate:	1 XX Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation 3 Suicide 6 Could not be	work?  M 1 ☐ Yes 2 ☐ N			
<u>N</u>	oital or A ours after eral Direc		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		City or Town,		
	To the Hosp within 24 ho To the Fune completely i	Medical	29a. Certifier (Check only one)  1 XXCertifying Physician: To the best of my knowledge, death or Check only one)  2 Medical Examiner: On the basis of examination and/or investig	gation, in my opinion, death occu leath occurred at the time, date	irred at the time, date and	place and due to the car	ice(c) and manner stated
	To with		29b. Signature and title of bertiller  MD	29c. License number  Doo667		d. Date signed (Month, I	Day, Year)
0	H-6		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	HOSPITALA	- 103 CLIN	MON, MD.	20735
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 4 2012 32. pegistrar's Signature	HOSP MACAL		,	

		,	1 - State of Maryland / Department / Departmen	artment of Health and M tificate of Death	lental Hygi	ene g, No. 2012	27734
	Physicia Medic		Decedent's Name (First, Middle, Last)  Joan Alice Riggs		2. Date of Death Month August	<sup>Day</sup> 1 2012	3. Time of Death 4:50 p. M
-	Examir		4a. Facility Name (if not institution, give street and number) Vindobona Nursing Home	4b. City, Town, or Location of Death Braddock Heights		4c. County of Death Frederic	
	Funeral Director		5. Social Security Number $ \begin{array}{ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Coun	**
	Maryland 28a-f shov atified at	Director	10a. State MD 10b. County 10c. City, Town or Loc Braddock			1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	s 23a or 2	Funeral Di	10e. Street and Number 6012 Jefferson Blvd.	10f. Zip Code 21714		Og. Citizen of What Coun United Stat	
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 X Yes 2 No	Vas Decedent of Hispanic Origin? (Spey Yes, specify Cuban, Mexican, Puerto F ☐ Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6 Specify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 ho giene. Ier than "na ist the Medic."; the Medic.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  1  Owner	ent's Usual Occupation ind of work done during most of workir O NOT use retired) /operator	ng	6b. Kind of Business/Ind	
yland	ld be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Frank Shuttleworth	18. Mother's Name Alice N	(First, Middle, Ma Maude Tag		
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imore	Page 1 al ment of H tant: If itel iury or oth		4 Donation 5 Other (Specify) Stauffer	crematory 8/14/	2012 F	Oc. Location - City or To	D
Ball	Depart Import any in			Name and Address of Facility State 621 Opossumtown Property 1985			
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Division of Vital Records,	sician: The law rec s certificate has bee director, page 2 sho	Be Completed	25. Was case referred to medical examiner?	26. Place of Death (Check	24a. Was an autopsy performe 1 Yes 2 only one)	prior to con death?	sy findings available npletion of cause of 2  No
of Vit	ding Physic th. After this ce funeral direc	유	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Maryner of Death 28a. Date of injury 28b. Time of		ne 5 Residence	ce 6 Other (Specify)	
Division	le Hospital or Attendir n 24 hours after death, le Funeral Director: Af pletely filled in by the fu	Certificate:	Natural 5   Pending   (Month, Day, Year)   Injury	M 1 Tyes 2 No	8f. Location (Stree City or Town, S	et and Number or Rural I State)	Route Number,
_	To the Hospita within 24 hours To the Funera completely fille	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death or control of the basis of examination and/or investigned only one)  29b. Signature and title of certifier	gation, in my opinion, death occurred at t	the time, date and pose, and due to the d	place, and due to the caus	se(s) and manner stated. ated.
D				00162223			
	Stat	9	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Pr  A 4 B C 4 B 0 A 0 7  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Enice	ND 2/7	202
E	Registra	- I		ake			

State of Maryland / Department of Health and Mental Hygien 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20/3 Revender Theodosha Roberts 0032A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINSULA REGIONAL Ned Ical NICOMICO If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth Funeral Days Min (Month, Day, Year) 220-26-1406 80 Director 1 □ M 2 🖺 F 12/04/1931 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f sho event, the Modical Examinar must be notified at 72 hours after death with the Maryland Director Maryland Wicomico Salisbury 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 200 Civic Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 X Never Married 2 ☐ Married ☐ Yes 2 🖾 No 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black If Yes, Give and Mental Hygiene. Is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Industry 11th laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Iona Jones permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any Injury or other traumatic is Fred Alexander Roberts traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwight A. Roberts 8428, 57th Avenue, Berwyn Heights, MD 20740 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Elzey UMC Cemetery 1 X Burial 2 Cremation 3 Removal from State 08/10/2012 Jesterville, Maryland 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Sightu of Funeral Service Licenses JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to ( r as a consequence of) Examiner Secuentially list rondlions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes 2 🛛 No ျှ 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 5 Pending М Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of hd title of certifie 29b. Signature 29d. Date signed (Month, Day, Year) 19 erson who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gary R. Slebzak 5:40 A August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 966 Dogwood Tree Drive Anne Arundel Annapolis . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 57 Director 217-56-2583 1 x M 2 □ F Yrs June 27,1955 Maryland Usual Residence of Decedent or 28a-f shov ?? is marked other than "natural", or items 23e or 28a-f sho traumatic event, the Medical Examinar must be natified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 966 Dogwood Tree Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. should be filed within 72 hours after of and Mental Hyglene. is marked other than "natural", or δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Kulis Malcolm Slebzak 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 966 Dogwood Tree Drive Annapolis, MD 21409 Lori Slebzak / Wife injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August permit. Page 1 a
Depertment of H
Important: if ite
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14, Baltimore, MD 2012 Metro Crematory, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.A. Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Prysician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician end for use es the burlei-trensit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) signed by the a d be deteched f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed been si should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes 2 Ho 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Corriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ames 509

Registrar

State

31. Date filed (Month, Day, Year)

AUG 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Amend #23a per PHY AACO Health Dept. 8-14-12 KAH 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/7/2/012 Physician/ 1145 Scott Harris Shapleigh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel **Examiner** AAMC Annapolis . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1XXM 2 | F (Month, Day, Year) 9/16/1971 147-70-3100 Director 40 PA Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director notified Davidsonville MD Anne Arundel 1 Yes XX No 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be Funeral items 23a 21035 USA 1320 Dickey DR. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc P. þ 1 Never Married 2xx Married hours after Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2XXNo Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 72 al Hygiene. life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) US Senate Special Projects Director other traumatic event, Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other tranmation. filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rochelle Jaffe Robert Morris Shapleigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Davidsonville, MD 21035 1320 Dickey Dr. Aurora Shapleigh Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 8/9/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 2 Ridgely Ave. Annapolis, MD 21401 Signature of Funeral Service Licensee 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Onset and Death** Physician/ Amyotrophic Lateral Sclerosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending ph IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a d be detached f g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à KESPIROTOR T 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Jas autopsy page perform death? certificate ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Other. မှ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No Director: / Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after hin 24 hours af the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

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gistrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 09:30 AM 2012 JOSEPHINE SCATTERGOOD August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Tranquillity at Fredericktowne Frederick Frederick Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 219-54-7698 1 🗆 M 2 💢 F 88 July 12, 1924 Ireland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Woodbine Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1601 Brittle Branch Way 21797 Great Britain Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ural", or iten I Examiner n 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 'natural", 3 ₩ Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ဂ္ Elizabeth Carroll Joseph Garraghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 1601 Brittle Branch Way, Woodbine, MD 21797 Meryl Ann Sullivan/Daughter or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 8/13/2012 | Alexandria, VA 4 Donation 5 Other (Specify) permit. 21. Signature of uneral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition 25 Years Physiciany Hypertensive Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Dementia 5 Years Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Dus to (or as a consequence of) Exami Cause (Disease or injury that initiated events as the burial-tran and Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate I 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ပ ER/Outpatient 3 DOA 1 Inpatient 2 I within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No injury 1 🔀 Natural Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 52323 August 13, 2012

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

AUG 1

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arks

M. Khalid Waseem, M.D., 1126 Opal Court, Hagerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month W. Stewart Raymond 12:02 PM Medical Aug 12 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 240 34 7095 1 X M 2 □ F Director 86 North Carolina April 18, 1926 Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🄀 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? by Funeral 20744 United States 7817 Jaywick Ave permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Armed Forces 1 X Yes 2 [ If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed 3 Widowed 4 Divorced WII Specify. **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Construction Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Preston Stewart Lillian Judd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7817 Jaywick Ave, Fort Washington, MD 20744 Joann S.Logan (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Aug 21 2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Sign twe of Funeral Service Licer Ferry Road, Clinton, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death AIters Immediate Cause (Final disease or condition Disco heroscelrotic 01000 Provincion/ Medical resulting in death) Examiner Sequentially list conditions, Examine il any, reading to immedicause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Tes 2 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After **Y** Natural 5 Pending Accident Investigation 1 🗌 Yes 2 No 24 hours after death Funeral Director: filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) within To the 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 08/13 D0064055

DHMH 17 Rev 06-2011

State Registrar Surratts Road, Clinton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 7503

Eric McDonald.

AUG 1 5 2012

31. Date filed (A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:24 P. M. Pauline Sullivan Louise Medical 4a Facility Name (if not institution, give street and number Location of Death Examiner 4c. County of Death 2 Wedict Center 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** MD Country) Jan 23 Months Year) 939 Director 34 4997 73 220 1 □ M 2 🕱 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified Yes 2 No Charles Hughesville MD ò 10e. Street and Numbe 10g. Citizen of What Country? be 23a Funeral Examiner must 7330 Stoneleigh 20637 USA Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 'natural", or 1 Never Married 2 Married 1 Yes 2 No 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Private Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertrand Angus Wells Esther Louise Johannes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grant Sullivan/son 7330 Stoneleigh Ct. Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lincoln Cem. 8-17-12 Brentwood, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME pusca Ione 2294 Old Washington Road Waldorf, Maryland 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HUPERCALCEHIA disease or condition resulting in death) UN KNOWN Medical Due to r as a consequence of: Breast CANCER Examiner METASTATIC UNKNOWN Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23h Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 4 ☐ Pregnam : 9 ☐ Unknown 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-12005/05 pause of death (Item 23a) (Type, Print)

Registrar

State

1870

Registrar's Signature

1 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 9:30 A M DOUST Edward M. Sedgwick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES PLATA MEDICAL 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min. 224-50-8044 **Director** 1 🗶 M 2 🗆 F 12/07/1940 71 V۸ Usual Residence of Dece or 28a-f show notified at 10d. Inside City Limits 10c. City. Town or Location 10a State Director 1 🔀 Yes 2 🗌 No MD Charles Waldorf should be filed within 72 nouse constand Mental Hygiene.
is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is marked other. 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 2401 Shade Oak Ct. 50707 AZU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?

Yes 2 \sum No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Army Sargeant - 1st Class U.S. Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic eve once. မ Richard McCoy Sedgwick Virginia Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Shade Oak Ct., Waldorf, MD 20601 Charmaine D. Sedgwick / wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State MD Veterans Cemetery 08/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee

Many E. Hedgy 22. Name and Address of Facility Strickland Funeral Services Hedgnow 6500 Allentown Rd - Camp Springs MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) ( r as a consequence of): Examiner bitus month ulcers Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last iding physician use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? been signed by the atte should be detached for Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has performed 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: I or Attending F work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation
6 Could not be eral Director: A 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practitioner: To the best of my knowledge, death 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tt & Muly MD Angust 11, 2012 D50152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 Miller MD, BLUD, SUITE B, GLEN BURNIE, MD AVIATION State AUG 1 5 2012 21061 Registrar

EDWARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Delores Jeanette Sartor 1206 201 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death TENINSULA Center SAC156414 HICOMICO REGIONAL MEDICAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 1 🗆 M 2 🗓 F 182-26-8723 80 6-4-1932 PA iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 720 10th Street, 21851 Apt 13 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specifolack 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaking Homemaker of Health and Mental Hygier of Health and Mental Hygier of ther traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Stanley W. Williams Mary E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 9th Street, Pocomoke, MD 21851 Dawn Frazier/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>| terusalem Bapt\_Cem 8-4-2012 | temperanceville, VA</u> 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith 21. Signs or of Funeral Service Licensee Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DISSEMINATED INTRAVACINLAR COAGULATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 24 h CERUSBICAL VASCUIRIR Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): After this certificate has been signed by the attending physician and structed director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 D0066111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY MO DANIEL G. MCCULLOUGH, 1324 BELMONT AVE A105 M.P. , FACS

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

21802

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daniel Joseph Terlizzi 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death APGIVANT MIDIPAL XILLANICO Centu 512130414 TENINSULA If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 182 12 427] 1 [X] M 2 □ F 88 Pennsylvania /24/1923 Usual Residence of Decedent or than "netural", or items 23a or 28a-f show the Medical Exeminer must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Cutlass Drive 21811 J.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 Il Hygiene. I other than "netural", If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Carrier US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ Mauro Terlizzi Susie Ricci permit. Page 1 and 2 should be Department of Health and Men Importent: If item 27 is marks any injury or other traumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Terlizzi / Wife Cutlass Dr. Berlin, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Eastern 8/14/12 Hurlock, MD Cemetery <u>Shore</u> 21. Signature of Funeral 22. Name and Address of Facility 108 William St. The Burbage Funeral Home MD 21811 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MUDCATOLAL disease or condition Medical resulting in death) Due to (or as a co sequence of): Examiner CATOLOGENIC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed ettending physician and I for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) 1 Yes 2 No ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? certificate 2 N 2 🗆 No To the Hospital or Attending Physicien: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Matural 5 Pending 2 No ☐ Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Gettiying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gettifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and addre

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

400 E. Shore

Dr.

SALISBURY MO

ss of person who completed cause of death (Item 23a) (Type, Print)

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32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 2012 Physician/ M 2339 JOYCE TROLL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER 200 BEACHCOMBER LANE OCEAN CITY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Davs Hours Director 219-18-8636 4-6-1925 MAINE 87 10d. Inside City Limits 28a-f shov 10b. County 10c. City. Town or Location 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 💢 Yes 2 🗌 No MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 200 BEACHCOMBER LANE 21842 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by should be filed within 72 hours after land 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER NONE 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental WALTER KIRKPATRICK CLYDE REDDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shou Department of Health and Important: If Item 27 is m any injury or other traum CONNIE A. TROLL/DAUGHTER 200 BEACHCOMBER LANE, OCEAN CITY, MD. 21842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State MELSON'S CREMATORY 8-10-12 FRANKFORD, DELAWARE 4 Donation 21. Signature of Funeral MELSON FUNERAL SERVICES, LTD. 38040 MUDDY NECK RD. OCEAN VIEW. 19970 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disc Immediate Cause (Final andromy Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this neutrinous hours. signed by the attending physician and Id be detached for use as the burial-trar burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

completely filled in by the funeral director,

Be |요 Certificate:

Medical

examiner?

Natural

27. Manner of

29a. Certifier

(Check

only one)

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To the within 2

State Registrar

2 Accident
3 Suicide Investigation 6 Could not be 4 Homicide

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4

5 Pending

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause |
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

work? 1 ☐ Yes 2 ☐ No

28c. Injury at

Other: 4 Nursing Home 5

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DREALL 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 12 2012 Year Joseph Taler 6:49 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1926 Thomas Drive Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 89 Davs Hours (Month, Day, Year) 217-34-8301 1X M 2 D F Director Yrs 01/10/1923 Poland Poland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1926 Thomas Drive 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Mantal Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White Specify 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 05 Elementary/Secondary (0-12) Family Practice 12 Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Abraham Taler Sofia Tobias 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1926 Thomas Drive Annapolis,MD 21409 Taler Bronislawa Wife 20a. Method of Disposition

1 

Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Kneseth Israel 08/15/2012 Annapolis, MD 21. Signature of Pay Service Licen 22. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 Tac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) 0 Medical Due to (or as a consequence) of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 4 No 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

To the I within 2.

State Registrar

29a. Certifier

29b. Sia

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James

31. Date filed (Month

only one)

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ture and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 7 5:26 AM Physician/ Earl Lee Timmons 4c. County of Death Medical 4b. City, Town, or Location of Death Salis bury 4a. Facility Name (if not institution, give street and number) Examiner 160mico Coastal Haroice at the Lako If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) Country 59 **Director** 220-52-2433 1 X M 2 □ F 10-14-1952 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No Salisbury Wicomico MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21801 710 Baker Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black White etc. 1X Never Married 2 Married δ Maryland 21215-0036 72 hours after SpecBlack 1 ☐ Yes 2X No Specify: If Yes, Give I Hygiene. other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Perdue Truck Driver 10 Department of Health and Mental Hygimportant: If item 27 is marked othe any injury or other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rocedia Fields Robert E. Timmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) W. Chestnut St, Delmar, MD 21875 Angela Daniels/Daughter 13 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation, 8-13-2012 Direct Dover, DE 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 21. Signature of Funeral Service License ell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ leuhemon Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician letely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Division of Vital Records, P.O. Box in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💹 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 4 lah 28d. Describe how injury occurred culc injury Natural 2 Accident 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1) 63199 7129/12 address of person who completed cause of death (Item 23a) (Type, Print) 110 EASTERN SHORE DR, SALISBURY, MD, 2184, 30. Name and 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State 2012

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 4116-HN Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Heritage Harbour Health&Rehab <u>Annapolis</u> Anne Arunde1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours Min. 421-60-4455 **Director** 1 □ M 2 🗓 F 66 7/15/1946 Alabama Usual Residence of Decedent or then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 2700 South Haven Road 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Ď 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Person permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other treumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph S. Nelson Goldie Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen R. Vaughn/Ex-Husband <u> 27211 Chipmans Lane Federalsburg, Maryland 21632</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 8/10/12 Edgewater, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATTUSHE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). ours after death. erel Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transif Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) e Hospital of 24 hours at Eunerel D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the within 2 To the P 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

Maryland 21215-0036

Baltimore,

68760

**Division of Vital** 

DHMH 17 Rev 06-2011

MD

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 13 2012

29d. Date signed (Month,

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 27<sup>Pay</sup> 2012 1:25 p M Ola Hester Wigfall Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Wicomico 3525 Texas Road Bivalve 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Director 218-16-9376 1 □ M 2 🗓 F 4-17-1918 MD Usual Residence of Deceden permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other than "neture!", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2X No Wicomico Bivalve 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21814 USA 3525 Texas Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 sp.B.lack 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homemaking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Dashiell Eliza Syrus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3525 Texas Road, Bivalve, MD 21814 Madeline Wigfall/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State Elzey UM Cemetery 8-4-2012 4 Donation 5 Other (Specify) Bivalve, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Home Salisbury, MD 21801 Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition A Physician/ Medical resulting in death) Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the deeth certificate be executed the ettending physician and the for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ be detached for in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physicien: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🗗 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sigi 29d. Date, signed (Month, Day, Year)

The same

State Registrar

31. Date filed (Month, Day, Year)

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reted cause of death (Item 23a) (Type, Print)

		•	For State of Mary  State Registrar	land / Depa <i>Cei</i>	artment of F <i>rtificate of L</i>	lealth and N Death	Mental Hyg	giene <sub>Reg. No.</sub> 2 (	012	27749
	Physicia		1. Decedent's Name (First, Middle, Last)  Alice A. Warfield			_	2. Date of Dea Month Augus	Day	20 <sup>Y</sup> fl <sup>ar</sup> 2	3. Time of Death 6:45P M
	Medic Examin		4a. Facility Name (if not institution, give street and number) BERLIN NURSING AND REHABILITA'	TION CEN	1	Location of Death	1111911	4c. Cour	nty of Death	
	Funeral		5. Social Security Number 6. Sex	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9, Birthp	lace (State or Foreign ry) yland
	Director	_	220-20-0620 90  Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Lo	cation		1 04/21/	1922_		Od. Inside City Limits
	Marylar 28a-f sh otified a	Funeral Director	Maryland Worcester	Ber						1 Yes 2 No
	with the 23a or	eral D	10e. Street and Number 9715 Healhway Drive		10f. Zip Code 2181	1		10g. Citizen o		try?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - America lack, White, e ify: Whit	tc.
ice 21215-0036	vithin 72 hour iene. ir than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give	dent's Usual Occupa kind of work done d O NOT use retired) <b>maker</b>		ing	16b. Kind of	Business Ind	lustry
Aland	d be filed w Mental Hyg arked othe tric event,	To Be	17. Father's Name (First, Middle, Last) Harry Swigert	rione	marce L	18. Mother's Nam				
eld, Maryl	2 should lith and h		19a. Informant's Name/Relationship (Type, Print)  Alice Kilgour/Daughter	_	ng Address (Street a					,
Warti <mark>Itimore,</mark>	ge 1 and nt of Hea : If item or other		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ Removal from State	0b. Place of Dispo		e)	Date	20c. Location	n - City or To	wn, State
Warti Baltimore,	permit. Pa Departmer Important any injury once.		4 □ Donation 5 □ Other (Specify) □ □  21. Signature of Funeral Service Licensee	22	Park Ceme 2. Name and Addres olloway F	s of Facility	8/2012		awn, M	
ï	0.0 = 60		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		01 Snow H	ill Rd	. Salish	ury. M	D 2180	Approximate
d	Physician/ Medical		Immediate Cause (Final		vdire	arres	+			Interval Between Onset and Death
	Examiner	er	Sequentially list conditions. b. Ayacc	Lensine	Hear	Disc	رجل			
	rcuted and transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.	preni	<u>~</u>					
09	cate be executed physician and the burial-transit	edical E	resulting in death) Last  Due to (or as 9 con  d.	)						
Box 687(	certifica anding ph use as th		IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pre	egnancy	Ectopic pregnanc			23d. [	Date of delive	ry
	he death y the atte ched for	hysicia	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of death 5	Other (specify)	у		N	Month	Day Year
ds, P.O	requires that the death certific been signed by the attending I should be detached for use as	ed by P	Part II. Other significant conditions contributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.				e cause of death? ably 4 Unknown
Division of Vital Records, P.O.	To the Hospital or Attending PhysIcian: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M					24a. Was a autop perfo		o. Were autop prior to con death? 1 \( \subseteq Yes \)	sy findings available inpletion of cause of
/ital	rsician; s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	2   ER/Outpatier	Othe	ace of Death (Checker: 4 Nursing Ho		longs e $\Box$ Or	ther (Specific)	
n of \	ding Phy h. After this funeral c	sate: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28b. Time of	28c. Injury work	at	28d. Describe h			
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, str ecify)			28f. Location (S City or Tow		ber or Rural I	Route Number,
	he Hospitz in 24 hours he Funera ipleted fille	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my kill only one) 3 Certifying Nurse Practioner: To the best of the best	nation and/or invest	tigation, in my opinio	n, death occurred a	t the time, date a	nd place, and o	due to the cau	se(s) and manner stated.
	To the with To to come		29b. Signature and title of certifier		29c. License	number (312 \$ 5		29d. Date sign	ned (Month, D	ay, Year)
	STC		30. Name and address of person who completed cause of death (	(Item 23a) (Type, F NAY DR		MD 21	811			
	Stat Registra	e ar	MARY CIARK 91/5 HEAITHN 31. Date filed (Month, Day, Year) 31. Registrar's Si	ignature	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ Eleanor Wilson Wiggins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomica bu 7. Age (In yrs. last birthday) If Under 24 Hrs Funeral 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 218-09-1000 1 🗆 M 2 🕱 F 12/26/1919 Maryland or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f shoeny injury or other traumatia event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21804 USA 1109 S. Schumaker Dr., Apt. 303 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Julia Virginia Ruby Price E. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4020 Wilkinson Rd., Havre De Grace, MD 21078 Richard W. Chase/Son W. 99 ≀ Baltimore, P 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2012 Salisbury, MD Salisbury Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility, Holloway Funeral Home Professional Association Domano 🗢 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or compil/ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) CARVICAL Onset and Death Physician/ SPINAL STENUSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and or use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funerel Director: After this certific: completely filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 405 Pl 52 1 Tes 2 PNO မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No Investigation
6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Day Ann Wood Debra Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death . PENISUUA ABBIONAL MEDICAL CENTER SALISBUR HICOMICO Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Director 1 🗆 M 2 🕱 F 54 225-90-08/17/1957 Massachusetts ir then "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Virginia Accomack Horntown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35077 Pine Oak Drive 23395 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 X Never Married 2 Married ۾ 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other then "r or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Sales Associate Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Leon Wood Fleta Hollar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 Edward Wood/Father 536 E. Reservoir Rd., Woodstock, VA 22664 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Wakeman's Grove COB 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2012 Edinburg, VA Cempter 22. Name and Address of Facility
HOLLOWAY FUNERAL HOME, PA Signature of Euneral Service Licensee thornwood 501 SNOW HILL RD. SALISBURY 21804 CF9P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 JE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, The law requires Completed 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Detaying Prijsclan. To the basis of my knowledge, beach occurred at the time, date and place, and due to the cause(s) and manner stated.

Detaying Prijsclan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ્જ who completed cause of death (Item 23a) (Type, Print) T SHORE DE, SALISBURY MD 21804

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0

Mile Marker 53.3 on I-95 South Baltimore	County of Death  N/A  DD/YYYY) 9. Birthplace (State or Foreign St. Country) Marc
4a. Facility Name (if not institution, give street and number)  Mile Marker 53.3 on I-95 South  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/II)	County of Death  N/A  DD/YYYY) 9. Birthplace (State or Foreign St. Country) Marc
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/I	DD/YYYY 9. Birthplace (State or Foreign St. Country) Marc
Martin David David Martin	Foreign St. Country) Marc  10d. Inside City Limits
Direction 157-96-1672   1⊠M 2□F   50 Yrs.   Months bays 10013   Mill.   3/25/196	Country) Marc  10d. Inside City Limits
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	
Burlington Willingbore	1 Yes 2 No
NJ Burlington Willingbore  NJ Burlington Willingbore  10e. Street and Number 28 Eagle Lane  08046	ren of What Country?
28 Eagle Lane 08046	USA
BUTTING ON WITTING DOTE  10e. Street and Number  28 Eagle Lane  10f. Zip Code  08046  11. Marital Status  1 Never Married  1 Never Married  2 Married  3 Widowed  4 Divorced fives, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Status)  18. Mother's Name (First, Middle, Maiden Status)  19. College (1-4 or 5+)  19. College (1-4	14. Race - American Indian, Black, White, etc.
1 Yes 2 No specify:	D11-
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. K	Specify: Black ind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17b. Decedent's Education (Specify only highest grade completed)  17c. Father's Name (First, Middle, Last)  17c. Father's Name (First, Middle, Last)  17c. Father's Name (First, Middle, Last)	
State of the state	der Services
9 Company of the second of the	ŕ
Joe Rolles    Joe Rolles   Marie Augusti	L N y or Town, State, Zip Code)
Berthe Augustin-Wife 28 Eagle Ln. Willingbore, N	J 08046
20a. Method of Disposition 1 Zeromation 3 Removal from State crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	ocation - City or Town, State
20a. Method of Disposition 1 ZBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20c. L 20c. L 20d. Method of Disposition 20c. L 20c. L 20d. Place of Disposition (Name of cemetery, crematory or other place) 20c. L 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20c. L 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery, crematory or other place) 20d. Place of Disposition (Name of Cemetery) 20d. Place of Disposition (Name of Cemetery) 20d. Place	nnaminson, NJ
19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City   19b. Mailing Address (Street and Number or Rural Route Number, City   19b. Mailing Address (Street and Number or Rural Route Number, City   28	
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot	
failure. List only one cause on each line.	Between Onset and Death
Examiner or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions,  if any, leading to immediate  Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or Infury that I. Mated	
events resulting in death) Last Due to (or as a consequence of):	
d.  AMENDED  AMENDED  AMENDED  AMENDED	
O is an analysis of the second	Date of delivery
23d. If yes, outcome of pregnancy 23d. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknown  23d. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown	Month Day Year
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco u	se contribute to the cause of death?  No 3 Probably 4 Unknown
Z4a. Was an autopsy	24b. Were autopsy findings available
24a. Was an autopsy performed?  1  Yes 2 No  25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only one)  27. Was case referred to medical examiner?  1  Yes 2 No  28. Place of Death (Check only one)	prior to completion of cause of death?
The second seco	1 Yes 2 No
25. Was case referred to medical examiner?    Solition   Check only one   Comparison   Compariso	ice 6 Other: Scene
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28b. Time of Injury 28c. Injury at Work? Pedestrian struck	
The struck of th	by tractor trailer
24a. Was an autopsy performed?  1	d Number or Rural Route Number, City
The state of the s	-95 South, Baltimore, MD
Color   Colo	
29b. Signature and title of certifier 29c. License number 29d. D	ate signed (Month, Day, Year)
O.C.M.E. Augu	ust 24, 2012
Name and address of person who completed cause of death (Item 23a)     Donna M. Vincenti, MD	
State 31. Date (14) (2007) 32. Registrar's granture	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Henry Armstead		1- For State Registrar		of Maryla		epartm Certific			d Ment	al Hyg		eg. No.	20	12	2	775
Physicia Medical Exami	_	1. Decedent's Name		ad, Jr				_			Date of Dea Month	Day	Year		3. Time of 0039	
modioa: Exami		4a. Facility Name (if		•			41	. City, Town, or	Location of		August 21		. County of	Death		
A.		Franklin Squ			_			Baltimore				В	altimore	Coun	ity	
Funeral Director		5. Social Security Nu			7. Age (In	yrs. last birt	hday)	If Under 1 Year Months Days		Min.	B. Date of Bi			Foreign		
Birector	1	13-82-25 Usual Residence of I	14	<b>X</b> M 2☐F		3	8 Yrs.				9/17	7/19	73	Cour	ntry) [M]	D
any .	ŀ		10b. County		10c.	City, Town	or Locatio	n							10d. Inside	City Limits
and show	5	MD	N/A		В	alti	more								1 X Yes	2 No
ie Maryland or 28a-f show fied at once.	rect	10e. Street and Num						10f. Zip Code			1	0g. Citiz	zen of Wha		ry?	
death with the Maryland or items 23s or 28s-f sho must be notified at once.	Funeral Director	1303 Sug	garwood				170.00	212					US			
eath w	ıner	Never Married	d 2 Marrie		rces?			Decedent of Hisp s, specify Cuban				>-	14. Race - White,		an Indian,	васк,
after d	by Fi	3 Widowed	4 Divorce	1 Yes	2 💢	NO	1 🗆 🕥	es 2 No	specify:				Specify:	Bla	ack	
hours a	ed b	15. Decedent's Edu						Usual Occupati				16b. K	(ind of Busi	ness/Ind	dustry	
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5-00 ed with ygiene other t	Completed	17. Father's Name (F	First, Middle, Las	•		* -	acir.		18.Mother's	Name (Fi	rst, Middle,			1,1 0	2010	
216 be fill ental H nrked	a	Henry Ar									ne Ha					_
MD 21215-0036 and 2 should be filed within 7 the and Mental Hygiene. m 27 is marked other than aumatic event, the Medical	- 1	19a. Informant's Nan eborah <i>A</i>						Address (Street								1221
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Dispe	osition		1	20b. Place o	of Dispositi	on (Name of cen			ate		ocation - C	•		
MOF		1 Burial 2	Other Specif		om State		ory or othe		pk	8/29	/2012	Rar	l I s b r	sto	าเสา	MD
Baltimore, permit. Pages I an Department of Hee Important. If ite injury or other tr	ŀ	21. Signature of Fun				11119	22. Na	orial I	of Facility	M.	arch	F/F	I-Eas	st	J W 11 /	110
		222 Part Fatanta	N OI			dansk Dans		01 E. I								1202
Physician Medical			one cause on e	each line.				, .			spiratory arr	est, sno	ck, or near	1	Between	nate Interval Onset and leath
Examiner	-1	Immediate Cause (F or condition resulting		Due to (or as a			13.0 <b>v</b> a:	scular L	)1sea:	se						
·		Sequentially list con-		)												
	in e	if any, leading to immodule Enter Underl (Disease or injury the	tyling €auea	Due to (or as a	consequer	nce of):								33		
ed nsit	Exar	events resulting in d		Due to (or as a	consequer	nce of):		=								
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68760, certificate be nding physic ise as the bun		IF FEMALE: 23b. Was decedent p	regnant in the	23c. If yes, o					Teatania			230	l. Date of de			
Box 6876 e death certificate the attending phy ed for use as the	iciar	past 12 months?			ant at time	of death 5		Ideath 3 L r (Specify)	Ectopic	pregnancy			Month	Da	iy	Year
. Bo he deat the at hed for	Physician/M	1 Yes 2 No		9 Unkilo							Loo- Dist					
Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death its after death.  al Director: After this certificate has been signed by the atter led in by the fluneral director, page 2 should be detached for u.	2	Part II. Other signifi	cant conditions	contributing to	death but	not resulting	g in the un	deriying cause gi	iven in Par	τι.	_	_	No 3	_	-	
ds, require	Completed										24a. Was					gs available
ecol ne law te has l	ğ	-		· <del></del> -			_				autop perfo 1 ✔ Yes	rmed?	dea	or to cor ath? Yes		f cause of
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Vita hysici this co	2		No			2 🗹 ER/O				Nursing H		Reside		Other		
n of iding F h. After	Ë	27. Manner of Death  1 X Natural	5 Pending	28a. Date (Month,	of Injury Day,Year)	28b.	Time of Inj	· 1	y at Work? es 2		d. Describe	how inju	ry occurred	1		
isio Atten er deat rector	icati	2 Accident	Investiga	28a Place	e of Injury -	At home, fa	arm, street,	factory, office bu	_		f. Location (	Street a	nd Number	or Rura	I Route N	umber. Citv
Div	Certification:	3 Suicide 4 Homicide	6 Could no determin	t be					-		or Town, S					,
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the line.		(0.10011 0111)		cian: To the besi	-				-			, ,				
To t To t	Medical	29b. Signature and ti		and manner st				29c. License					Date signed			ar)
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12	ŀ	30. Name and addres		•			alti	Chrack Deli	ma a = a = 5	ID 2422	2	<del></del>				-
y St	ate	Ling Li, MD 31. Date filed (Month		Medical Exan	gistrar's Sig		aiiimore	Street, Balti	more, IV	10 2122	J					
Regist		AUG 3 0	2012	2 min	1	frank										

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)
AUG 3 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend #9,11,12,15,16a&b,17,18,20a&b&22chPer FHG932
Registrar AMEND TTFM/8,10b-e,19a,b,perFh,0932,167/9743,185

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

10/17/2012 Per FHG932

10/17/2012 Per FHG932

10/17/2012 Per FHG932

10/17/2012 Per FHG932

10/17/2012 Per FHG932 1. Decedent's Name (First, Middle, Last) . Date of Death 3. Time of Death Physician/ Month 20/3 ALQUE/INE 12X4Ndex Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BalTIMOSE HOSPITAL Louis Social Security Number 6 Sex 8. Date of Birth7/23/1961 9. Birthplace (State or Foreign (Month, Day, Tear) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 🗆 M 2 🖵 F Months Hours 216-78-1344 (Month, Day, 51 Colorado Yrs Director <del>1961</del> Usual Residence of Decedent show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A 28a-f 1 Yes 2 No MD **Baltimore** 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 2010 2110 Harman Ave. Funeral 23a 21230 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 2-unk 1 ☐ Yes XX No If Yes, Give Year or Dates. 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ò δ XX Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No Specify "natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupationum (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Unit and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 CareGiver unk unk Self traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) -unle မ Ralph Alexander Hilda Luckett 19b. Majing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2110 Harman Ave: Baltimore. MD 21230 19a. Informant's Name/Relationship (Type, Print)

Delena Alexander (Daughter)

Delena Anderson Department of Health a Important: If item 27 is any injury or other trae -Harman Ave; Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Onsite Crematory 9/06/2012 4 Donation 5 State (Specify) in Baltimore, MD permit. I e Funeral Service Jeen Brown Function Board No. Fulton Ave 1235 W. Baltimore St; Baltimore, MD 2120721217 irector 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Fi et and Death (Final Physician HCMO TIL ALTED INTESTINAL Medical resulting in death) Due to (or as a consequence of): Examiner KATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or agree consequence of): 211717 Exam and burial-tran Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 1 Yes 2 Unknown detached Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ I MANDO Leticiary Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed should neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has page 2 autopsy performed? Yes 2 No After this certificate 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 욘 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending death. 2 Accider
3 Suicide Accident Investigation within 24 hours after deat To the Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) ρ 00055243 681140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balti Mori Bilti More I FILLS Maryland dolo Morrisse 000 WELL 2/233 31. Date filed (Month, Day, Year) 32. Registrar's Sig ature State 2012 AUG 30 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date Month 8 2. Date of Death 3. Time of Deat Physician/ Year HUAMS 12:28pm 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) or Location of Death **Examiner** 4b. City, Town, SAM Apri HAN 13altimore If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 220.14.0007 OH DA MD **Director** Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore Kandallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 3717 Lamoine Road USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Aide Libran 12th grade NEAVS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mars Clem Yancey Sallie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Eaton amune Road Randallstown MD 21133 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD 05 butus Memorial Park Vaugno C. Greene Funeral services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kandallstown MD 211 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part 1. Enter the shock, or leart Approximate Interval Between Immediate Cause (Final Onset and Death 54011 Cell Lung Carcer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): *k*aminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s performed' this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 058570

Registrar

State

DHMH 17 Rev 7/2009

parke

560 ( Loch Raven Blad Baltine 171)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrance 6. B. M. M. M. 560 ( 6

32, Registrar's Signature

31. Date filed (Month, Day, Year)

AUG 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	_ State	ryland / Depa	rtment of He			2 U I	2	27757
			1. Decedent's Name (First, Middle, Last)		infoato of De	Jacon	2. Date of Deat			3. Time of Death
	Physicia Medic	_	SUE ANDREWS				Month	21 20	Year	6:30 AM
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County		
_/			SAINT THOMAS MORE  5. Social Security Number   6. Sex   7. Age	(In yrs. last birthday)	WYA: TT If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			orge's
	Funeral Director		243-94-2952 1 □ M 2 ⊠ F	62 Yrs.			Feb. 4, I	50	Nort	h Carolina
	E OW		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ation					10d. Inside City Limits
	aryland a-f sh fied a	cto		Greenvil						1X□ Yes 2 □ No
	or 284	ä	NC Pitt  10e. Street and Number	Greenvii	10f. Zip Code		1	I0g. Citizen of \	What Cou	intry?
	with 1	Funeral Director	1100 B Vandyke Street		27834			USA		
	death item	Fur	11. Marital Status 12. Was Decedent Ev Armed Forces?	lf.	as Decedent of Hisp Yes, specify Cuban,				e - Ameri k, White,	can Indian, etc.
5	al", or	d by	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ № 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1	☐ Yes 2X No	Specify:		Specify	B1	ack
5	hours natur dical I	olete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupat	ion ring most of worki	na	16b. Kind of B	usiness Ir	ndustry
Z	hin 72 ne. than ' te Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5-	ife. DC	NOT use retired)	g		Culina	<b>*</b> 37	
7 0	ed wil Hygie other ent, th	a)	10   17. Father's Name (First, Middle, Last)	Che		18. Mother's Name	e (First, Middle, N			
lan I	d be fil dental rked tic ev	욘	Roy Steveson			Bertha	Andrews			
Baltimore, Maryland 21213-0036	should and N is ma		19a. Informant's Name/Relationship (Type, Print) Clifford Andrews (Son)	19b. Mailin	g Address (Street an	d Number or Rura	l Route Number,			Code)
e o`	and 2 Health em 27 ther to		Clifford Andrews (Son)  20a, Method of Disposition	737 C 20b. Place of Dispos	ircle Dri			NC 27	858 - City or 1	Town State
0	age 1 ant of 1 it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem	natory or other place)	9-1-2		Greenvi		· -
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tier Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature   Funeral Service Licensee	22	Name and Address	of Facility Met	ropolit	an Fune	ral	Service
ñ	Per market		> sun bland		5517 Vine				A 22	310
			23a. Part . Enjer the disease, or complications that caused shock, or heart failure. List only one cause on each line.	100	r the mode of dying,	such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
20	nysician/ Medical	P	Immediate Cause (Final disease or condition resulting in death)	consequence of):					. 1	
	Examiner		CUA	consequence or,						YEARS YEARS
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	and and transi	Examine	Cause (Disease or linjury	consequence of):					-	167 16 3
2	te be executed hysician and he burial-transi	dical E	d d	,						
2/60	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	0	IF FEMALE:							
	th cert ttendir or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of	2 ∐ Fetaldeath 3 ⊑					ate of deli	very Day Year
Box	the a	Physician/M	1   Yes 2   No 9   Unknown   Unknown	time of death 5 L	Other (specify)					
л. О	The law requires that the death rate has been signed by the atte page 2 should be detached for		Part II. Other significant conditions contributing to death but	18	nderlying cause give	en in Part I.	23e. Did to	bacco use cont		the cause of death?
ďS,	quires en sig ould b	ted	Chronic respiratory fa	ilure			1 🗆 Y	- J		obably 4 Unknown
Division of Vital Records,	law re nas be e 2 sho	Completed by	Dysphasia				24a. Was a autop: perfor	sy		opsy findings available completion of cause of
2	r: The ficate l		25. Was case referred to medical		26 Plac	ce of Death (Checi	1 Tyes	2. No	1 🗌 Yes	2 🗆 No
Vita	ysicial s certi directo	To Be	examiner?	ent 2 ER/Outpatien	_ Other	. /	ome 5 Reside	ence 6 🗆 Oth	er (Speci	fy)
0	ng Ph fter thi meral		27. Manner of Death 28a. Date of injur 1, Natural 5 ☐ Pending (Month, Day,	y 28b. Time of injury	28c. Injury work?	_	28d. Describe ho	w injury occur	red	
ion	ttendii death. :tor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ry - At home, farm, stre		/es 2 □ No	28f Location (Si	treet and Numb	er or Run	al Route Number,
NIS	al or A safter I Direc d in by	Ş	4 Homicide determined building, etc		oc, lastory, omos		City or Town		0. 1.0.	
_	To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiners of	camination and/or invest	tigation, in my opinior	<ul> <li>death occurred a</li> </ul>	t the time, date ar	nd place, and du	ie to the c	ause(s) and manner stated.
	the Fithin 24	Μe	only one) 3 Certifying Nurse Practioner: To the to 29b. Signature and title of certifier	best of my knowledge, o	death occurred at the 29c. License	time, date and place	ce, and due to the	cause(s) and m	anner as	stated.
	<b>≒ ≽ ∺</b> 8		De Male M.	D.		2168		08	21	2612
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print)					
	IV		RURENT MONEIL 4922 31. Date filed (Month, Day, Year) 32. Registra		AVE NY	ATTS VICLO	ND			
	Sta Registr		AUG 3 0 2012 General . B.	r's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August Agatha E. Allen 2012 2:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Montgomery Rockville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Days Hours Min. Grainia (Caratry) 578-20-7270 (88/07/1921 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Rockville Maryland Montgomery 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 299 Hurley Avenue 20850 u.s.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Was Decedon.
Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Caucasian 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) File Clerk National Geographic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ragland Eubank Telula Spilman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph Sawyer Allen - Son 21741 Leatherleaf Circle, Sterling. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 08/30/2012 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Funeral Service License 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Yes 4 ☐ Pregnant 9 ☐ Unknown been signed by the s should be detached Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? nona 24a Was an has page 2 performe this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JULIA KARN Stato 205 10110 Mojecular Dr 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygie 12 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Tessie Austin Medical 2012 12:36 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NIA Bultimore Bon Secours Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 216-16-9358 1 M 2 VF Year 916 **Director** Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside Cjty Limits Director MI Hmore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 609 Funeral 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes, Give 1 🗆 Yes 2 🗹 No Specify: Blac "natural", 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H 0 Maaq 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shount Health and item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggie to more 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) altimore 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call iac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malnutrition disease or condition claus Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or linguithat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phy: attending philosophia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the a 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hyportension, hyporlipidemia, premous cerebrovascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown accident 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed? Yes 2 No page certificate 2 🗌 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? hin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 2 Accident
3 Suicide
4 Homicide 2 No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature D73195 August 25, 2012 MD, Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Unit 1504 Baltimore 21202 675 Milan Vora President St. 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

68760

Box

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sheila M. Barker 11:130 2012 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** gnes 7. Age (In y 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 223-84-4215 54 1 □ M 2 🔀 F June 25,1958 Maryland Usual Residence of Decede or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Gwynn Oak 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? . Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be I Funeral 21207 **USA** 1505 Clairidge Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) St. Timothys School Teacher and Mental Hygie is marked other injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည Patricia Wagner John Stewart Boulter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 1505 Clairidge Road Gwynn Oak, Maryland 21207 Michael W. Barker/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 108/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. Custer ensestephanie 301 Frederick Road Catonsville, Maryland 21228 Enter the disease, or complications that caused the death not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eac Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir anding physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

Unknown Month Year 5 Other (specify) Day Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director, After this certificate I 2 **N**o funeral director, 25. Was case referred to medical 26. Place of Death (Check only one. Be examiner? Hospita Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) ne and ad Are Baltimore MO State Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ DONE 1.45A USI MARCIARET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Aughsburgh Lutheran Home Baltimore If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min May 10, 1913 Mary land **Director** 99 216-01-651 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director 1 Fyes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21207 with 23a Funeral 6825 Campfield Rd Apt 1A items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🛂 No Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha secretary unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Katheryn Jame McMullen William A. Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Marquate; Lutherville, MD 21093 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Paul W. Boone - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Ronald S Director 655 W. Baltimore St; Baltimore, MD 21201 Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NEUMONIA Immediate Cause (Final disease or condition Ptoysician/ PIRATION Medical resulting in death) Due to (or as a nsequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RIENSION 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No has this certificate Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (C\_eck only one) Be examiner? Hospital: Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 24 hours after death
Funeral Director: After thi
eted filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signaturg and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHANI, WINGS HSNEEM mi MILL 1529 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Clarence M. Banks, Jr. 8:10 PM Medical August 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore N/A **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 218-60-1578 Director 60 1 X M 2 - F 6/28/1952 Usual Residence of Decedent MD 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at Director MD N/A 1 X Yes 2 No Baltimore ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a Belvedere Ave. Apt. 3800 W. 518 21215 USA or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 X Yes 2 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural" 3 Widowed 4 Divorced Specify: Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Disabled N/A Be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be t 2 Clarence Banks, Sr. Ollie McMillion 1 and 2 should t f Health and Me and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 sie McMillion-Sister 30th St. Baltimore, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemet. :8/30/2012 Baltimore, MD F/H-East 21. Signature of Funeral Service Licensee March 22. Name and Address of Facility 1101 E. North Ave. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician iver tailure due Hepatocellular Carciname maroh Medical resulting in death) Examiner Sequentially list conditions, it any, leading to incrediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 2 No Yes the g 🗌 Unknown 9 🗌 Unknown by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ of Chronic Disease, Hyportension Completed 1 Yes 2 No 3 Probably 4 Unknown Heart Failure 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

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Sinailtospiral of Batomore, 2401 W. Belevedere Ave, Batomore, MD 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 2012 Month **Physician** 12:40AM Martha Jean Beauchamp August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Princess Anne Somerset iving of Manokin Aurora Sonior 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Nov 14, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** Hours Days 1 □ M 2 🖾 F Yrs 85 Director 214-22-8809 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Merical Example country or other traumatic event, the Merical Example country once. Princess Ann 1 ☐Yes 2 No Somerset Director MD 10g. Citizen of What Country? 10f. Zip Code 21853 10e. Street and Number 12429 Loretta Rd; Apt 3 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cashier accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Lillian Evans Charles Franklin Middleton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 645 Daniel Dr; Newport News, VA 23601 19a. Informant's Name/Relationship (Type. Print) Elaine Brimer - niece 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licenses Ronald St. Wa 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Puter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Failure to Minine one monto /Medical Due to (or as a consequence of): **Examiner** ASWD 15 years Sequentially list conditions, if any, leading to immediate cause Enter the defining Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) the 9 🗆 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mm ram 0051359 August

State Registrar 1415 - S. DIVISION

ST, SALISBURY, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. USHA

AUG 3 0 2012

31. Date filed (Month, Day, Year)

NATESAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. #16a&b \$#5\$ State of Maryland / Department of Health and Mental Hygiene 1 \_ For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bakari Physician/ George 7:44 a M ngust 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's mergency Repurs france 5. Social Security Number unk 6. Sex Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 62 465-89-3741 Director 1**X** M 2 □ F TANZANIA Jan 10, 1950 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f 1 🗆 Yes 2 🏪 No Alexandria VA 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a 22306 2910 Furman Ln. 11. Marital Status **-unk** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X XIVo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 XXvivorced Year or Dates 16a. Decedent's Usual Occupation **Unk** (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry UNK 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Engineer <del>- unk</del> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ဂ္ Bakari Cholicho MoHamed Esha Mwizagu 19a. Informant's Name/Relationship (Type Print)
Saidi Ally Bakari
Anthony Bukari - sor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 McDuffie Road Austell, Ga. 30106 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Method of Dispusition.

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

\*\*Cooperation\*\* In State 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 4 ☐ Donation 5 🕅 Other (Specify) 22. Name and Address of Facility State Anatomy Board Si ma. e of Funeral Service License Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Fatal Cardrae Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in resolute cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month the g 🗌 Unknown g 🗌 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1, 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag-1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Orive Cheverly Las Parid Mayo, MO 31. Date filed *(Month, Day, Year)* **AUG 3 0 2012** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert A. Blocher, Jr. DOAM 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Funeral 7. Ane (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Director 219-28-2499 81 1 🛛 M 2 🗆 F Nov. 14, 1930 Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 21228 USA 105 Maiden Choice Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 X Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Parts Clerk Automobile permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert A. Blocher Ruth Folckemmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Concord Drive; Sykesville, MD 21784 Brendan Gable Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 8/29/2012 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 . Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Farction Onset and Death Physiciani Myocardia disease or condition resulting in death) UNKNOWN Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ate has been signed by the attending physicien and page 2 should be detached for use as the burlal-transi Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Box ( 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 Yes completely filled in by the funeral director. Vital 25. Was case referred to medical examiner? Certificate; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA o 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After I 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Relation Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe MP 047353 August 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q May land 21229 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) AMonth 2. Date of Death Physician/ Edward A. Branning, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 88 Director 219-10-0885 1 X M 2 □ F May 19, 1924 Maryland 1 and 2 should be filad within 72 hours after death with tha Maryland of Health and Mantal Hyglane. Itam 27 is marked othar than "natural", or Itams 23a or 28a-f show othar traumatic avant, the Modical Examinations to the confliction of the conflictions of the confl 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21228 USA 719 Maiden Choice Lane HR615 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces δ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications 12 Switchman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Connelly Edward A. Branning, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Theresa Branning 719 Maiden Choice Lane HR615; Catonsville, MD 21228 Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Paga 1 a Department of H Important: If Its any Injury or ot 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory Glen Burnie, Maryland 4 Donation 5 Other (Specify) 9-5-2012 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DNFARCIDON Pnysician/ MYOCARDDAR MANUTES disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MERT ENSDON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ODABELES Aftar this certificate has been signed by the attending physician and funeral director, page 2 should be deteched for use as the burlal-transit YPE II that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ō. Completed by RENAL FADLURB C HRANDO Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after daath,

To tha Funaral Director: Aftar thi
complately filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attanding 24 hours after daath. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier ٥ 29d. Date signed (Month, Day, Year) AUBUST 29,2012 022114 ORMBAN BARCHESS was 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERTCH # (8 BACACHORE MARGIAND 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29 2012 2012 4:10 Elizabeth ам Gant Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore 109 Brightwood Club Road Lutherville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 239-30-6341 96 Feb. 11, 1916 North Carolina **Director** 1 □ M 2 🔀 F or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 109 Brightwood Club Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 9 Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Gilmer Banner and Mental Joseph Erwin Gant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 10802 Greenspring Avenue Brooklandville, MD 21022 Elizabeth Blue daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite 1 Burial 2 X Cremation 3 Removal from State Aug 30,2012 4 Donation 5 Other (Specify) Metro Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FaMintchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work Division s after death. 1 Yes 2 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined filled in 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely within 2 To the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Mghth, Day, Year) 08/29/2012 vno completed cause of death (Item 23a) (Type, Print) 100 30 N Charles Street Baltimore 31. Date filed (Month, Day, Yee 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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	4	For State Registrar	State of I	viai yiai i	•	tificate			and iv	icitiai i iy	Reg. N	0.0	112	27	768
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Examin		4a. Facility Name (if not institution, g		)		4b. City,	Town, or	Location	of Death	8	4	c. County	of Death		
***		Southern Maryla 5. Social Security Number 6			and birdh days	Clin		If Under	24 Urs 1	0 Data of Di		Princ		orge's	
Funeral Director		245-56-2578	1 □XM 2 □ F		ast birthday)  Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Coun	**	
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aryland B-f sh fied a	cto				y, Town or Lo	cation								0d. Inside Cit 1 🗡 Yes	ty ⊔mits 2 □ No
the Ma or 28		MD Prince  10e. Street and Number	George's	Sul	tland_	10f. Zip	Code			1	10g. 0	Citizen of V	Vhat Cour		
n with	Funeral Director	3940 Bexley Plac	e Apt. 815	5		207	46				US	A			
r item	린	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceden	?	S. 13. \	Was Deced f Yes, spec	lent of Hi ify Cuba	spanic Ori n, Mexicar	gin? (Spe ı, Puerto I	cify Yes or No- Rican, etc.)	•		e - Americ k, White,		
036 s after ral", o Exam	d be	3 ☐ Widowed 4 ☑ Divorced	d 1 ☐ Yes 2》 If Yes, Give Year or Dates			1 🗌 Yes	2X□ No	Specify:				Specify:	Blac	k	
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ylar Id be I Ments arked	잍	Brinkley Bar	nes		_			Le	la Be	ell Gra	у				
Mar 2 shou h and 7 is m traum		19a. Informant's Name/Relationship	(Type, Print)							Route Number				iode)	
re, l l and 2 l Healt Item 2 other		Leon Barnes/Son 20a. Method of Disposition			Place of Dispo	sition (Nan	ne of	- 1		tland,_	_		City or To	wn, State	
MO Page Tent of		1 X Burial 2 Cremation 3		te Ha	rmony	natory or o Cemet	ther plac cery	e)	09-0	1-2012	La	ndove	er, M	arylan	ıd
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fine 77 is marked other than "natural:", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	7	22					. Jenki . Hyatt				-	nc.
		23a. Part 1. Enter the disease or co shock, or heart failure. List onl	omplications that cause on each	ed the deat	h. Do not ente	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate	
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Medical Examiner		resulting in death)	Due to (or a	is a consequ	uence of):										
oir d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	ıs a consequ	uence of):									_	
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Division of Vital Records, P.O. Box 68760 mathe Hospital or Attending Physician: The law requires that the death certificate to the Punca after death.  The law requires that the certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	h 2 ☐ Feta tat time of o	al death 3	Ctopic point of Other (sp	pregnanc pecify)	; <b>у</b>					te of delive onth	-	Year
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Spital spital hours neral y filled	ical	29a. Certifier 1 Certifying P	hysician: To the best	of my know	led <b>g</b> e, death	occurred a	t the time	e, date and	l place, ar	nd due to the c	ause(s)	and manr	ner as stat	ed.	
the Ho In 24 Ine Fu	Med	(Check 2   Medical Exa only one) 3   Certifying N	miner: On the basis of urse Practitioner: To	f examination	n and/or inves	tigation, in	my opinic	on, death o	ccurred at	the time, date	and plac	ce, and due	e to the ca	use(s) and ma	nner stated
F 2 5		29b. Signature and title of certifier		MA	,			number	) _		29d. D	ate signed	(Month,		
		30, Name and address of person wh	no completed source =	f death /lto-	23a\ /Ti-no [		00 (	5498	0		0	211	20/	4	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 24° 10:15 PM 2012 William R. Buchanan, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Blakehurst Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 219-10-3733 Director 1 XM 2 □ F Yrs. 1926 86 July 25, Maryland items 23a or 28e-f shov wr must be notified at 10b. Count filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Ocean City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 724 South Surf Drive 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after obeartment of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or eny Injury or other traumatic event, the Medical Examinantic present, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Judge Circuit Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rephus C. Buchanan Mary Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Saxon Hill Drive; Cockeysville, MD 21030 John S. Buchanan son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specifyent ambrent Dulaney Valley Mem Gardens 8/29/2012 Timonium, MD . Signature of Funeral Service License 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to anniverlate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed es the burial-transit 9 Hospital or Attending Physician: The law requires that the death certificate be executed thours after death.
24 hours after death.
Funeral Director: After this certificate hes been signed by the attending physician end letely filled in by the funeral director, page 2 should be detached for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) |2 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 5 Pending ☐ Natural 2 Accident 1 Yes Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely f 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)
AUG 3 0 2012

Sharin M. Berneray

32. Registrar's Signature

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & NARON M. KERN, CRWP, 1055 W. JOPP H.

RO48402

8/28/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eleanor Bertha 8:10PM Biedronski 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death County of Death 3Altimore HOSPITAL Rose DA/e 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Min 212-26-7277 1 □ M 2XXF **Director** 84 Maryland Feb. 7, 1928 or 28a-f show notified at 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore 1 Yes XX No Essex ELEANORA 10e. Street and Number 9 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 8620 Kelso Drive, Apt B307 21221 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married by 215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 2 12 Service Food Industry Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Kutrik Bertha Postuszna 19a. Informant's Name/Relationship (Type, Print) ant: If item 27 is ry or oth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele T. Lagana -Daughter 7111 Brookshire Lane, Cockeysville, MD 21029 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Parkwood Cemetery Aug. 29, 2012 Baltimore, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
COOO Version Read Parkyille MD 21234 0 21. Signature of Funeral Service Licensee 8800 Harford Road, Parkville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition condition) Approximate Interval Between Physician Onset and Death **Medical** resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed?

1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: ျင Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work Accident
Suicide 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 8/25/ 064480 30. Name and address of begon who completed cause of death (Item 23a) (Type, Print) FIJAHUSSEIN 9000 FrANKlin SQUARE DrivE BAHIMORAMD 21237 MUSTATA HAS 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Ivial State Of Ivial Registrar	ryland / Depa Cer	tificate of D			g. No. 201	2 27771
	Physicia		1. Decedent's Name (First, Middle, Last)  Edward Fra	ınklin Bar	r		2. Date of Death Month	25, 2012	3. Time of Death  1:00 a M
~	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	Rugust	4c. County of De	ath
	Euporol		Suburban Hospital 5. Social Security Number   6. Sex   17. Age (//	n yrs. last birthday)	Be If Under 1 Year	thesda If Under 24 Hrs.	8. Date of Birth		ntgomery
	Funeral Director		578-30-3164 1X M 2 □ F	85 Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear)	irthplace (State or Foreign country)
	od at	ī	Usual Residence of Decedent  10a, State 10b, County 1	0c. City, Town or Loc	ration		10/09/	1926   Wa	shington, DC  10d. Inside City Limits
	larylar Sa-fsl ified	Director	Maryland Montgomery	oc. oity, fowr or Loc		nevy Chas	e.		1 🗆 Yes 2 🛣 No
	the N	l Dir	10e. Street and Number		10f. Zip Code	<u> </u>		g. Citizen of What (	
	th with	Funeral	8207 Meadowbrook Lan			20815		и	.s.A.
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 🏋 Married  12. Was Decedent Eve Armed Forces?  1 □ X Yes 2 □ No If Yes, Give	Korea 📗	Vas Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
00-	hours natura ical Ex	Completed	3 — Widowed 4 — Divorced Year or Dates.  15. Decedent's Education	WWII	ent's Usual Occupa		1	6b. Kind of Busines	White
215	in 72 l e. han "r e Med	omp	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	rind of work done d O NOT use retired)		ing	ob. Kind of Busines	5/Industry
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lano	be filed lental Hy rked oth ic event	70 E	Walter Edgar	Barr			e (First, Middle, Ma ace. ไมลาเ	iden Surname) Ene Malla	лd
lary	should and N is ma auma	į.	19a. Informant's Name/Relationship (Type, Print)			nd Number or Rura	al Route Number, C	ity or Town, State, 2	Zip Code)
e, ≤	and 2 Health em 27 ther tr		Angela A. Barr - Spouse  20a. Method of Disposition						land 20815
mor	Page 1 ment of ant: If it ury or o		1 X Burial 2 Cremation 3 Removal from State		natory or other place	e)	1	0c. Location - City of	Maryland
Baltimore, Maryland 21215-0036	permit. F Departm Importa any injur		21. Signature of Funeral Service Licensee						l Home, Inc.
8	9 9 E 8			-32 11	800 New +	lampshire	Ave., Si	lver Spri	ng,MD 20904
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	Medical		disease or condition resulting in death)  a. Athermolymphore and the properties of t	rosclerot onsequence of):	ic Cardio	vascular	. Disease		Years
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687			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy				201 Date of a	
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P.O. Box	it the c i by the etache	Phys	9 ☐ Unknown			in De All			
ς, σ.	res tha signec d be d	Completed by	Part II. Other significant conditions contributing to death but  Severe Hyponatremia, Gastr						to the cause of death?
ord	v requi	olete	Chronic Obstructive Pulmon				24a. Was an		utopsy findings available
Rec	The lav ate has page 2	Som	Failure To Thrive, SIADH.	so eg vos es	<u>,</u>		autopsy performe 1 \(\sum \) Yes 2	prior to ed? death?	completion of cause of
tal	Physician: T r this certifica eral director, p	Be	25. Was case referred to medical			ice of Death (Check		A-1101 121	2 2 110
Ž	Physi r this c aral dir	<u>ان</u>	1 ☐ Yes 2 🔏 No Hospital: 1 💢 Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatient	t 3 DOA Other	4   Nursing Ho		ce 6 Other (Spe	ecify)
Division of Vital Records,	nding ath. r; After	icate	1 X Natural 5 ☐ Pending (Month, Day, Y 2 ☐ Accident Investigation		work?		28d. Describe how	injury occurred	
Visio	or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	et, factory, office		28f. Location (Stre City or Town, S	et and Number or Fi State)	ural Route Number,
٥	pital o		29a. Certifier 1 Certifying Physician: To the best of my	knowledge death a	sourced at the time	data and place a			
	ne Hos n 24 h ne Fun pletely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the basis of exam	nination and/or investi	igation, in my opinior	n, death occurred at	the time, date and	place, and due to the	e cause(s) and manner stated.
	with To th		29b. Signature and title of certifier  WWW SWW M	1	29c. License			d. Date signed (Mor	
						D53367		August 2	5, 2012
`	5+1		<ol> <li>Name and address of person who completed cause of deat</li> <li>Shyamsumar Rajan M.D., 9801</li> </ol>			Suite 117	. Silver	Sprina.	MD 20910
A.	Stat Registra	_	31. Date filed (Month, Day, Year)  AUG 3 0 2012	Signature			,	,,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August Hubert Paul Bonhomme 2012 11:50 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caseu House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Months Days Hours (Month, Day, Year) Director 577-64-1004 1 🕅 M 2 🗆 F 67 Yrs. March 19.1945 Haiti Usual Residence of Deceden tal Hygiana. 5d other than "natural", or items 23a or 28e-f show avent, II a M-dic.l Ex.miner must be notified at 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Rockville Maruland 1 Yes 2X No Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10500 Rockville Pike, #906 20852 Haiti hours aftar daath Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Ernest Bonhomme Georgette Polynice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dapartment of Haalth ar Important: If itam 27 Is any Injury or other trau once. 10500 Rockville Pike, #213. Rockville. MD 20852 Michele Bonhomme - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory: 08/31/2012 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2009 Immediate Cause (Final Priysician/ Metastatic Rectal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attanding physician and for use as tha burlal-transi Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlal-trans. Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) HOSPice 1 🗆 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury\_at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0060634 August 25, 2012

State Registrar Bindu C.

P

6001 Muncaster Mill Road, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph, M.D.,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			ease Type or Pri			ndelible Ink artment of H			_		jible.	
		For State Registrar				tificate of E			-	Reg. No. 2	112	27773
Physicia Medi		Decedent's Name (First, Mich.	ddle, Last) Irene A. Bl	rittl	ebank				2. Date of De Month AUGUS	t 25, 2	0 1°2"	3. Time of Death 11:10 p M
Exami		4a. Facility Name (if not institut	·			4b. City, Town, or				4c. County	y of Death	
Funeral		5. Social Security Number	Nursing Home 6. Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year	indy S	24 Hrs.	8. Date of Birt		9. Birthp	tgomery  place (State or Foreign
Director	ļ	216-40-5926 Usual Residence of Deceden	1 □ M 2 🂢 F	10	5 Yrs.	Months Days	Hours	Min.	Month, Da.  June 2		Coun	England
yland -f shov ed at	tol	10a. State 10b. Cour	nty	10c. City	, Town or Lo	cation	4.1				1	0d. Inside City Limits
2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland M 10e. Street and Number	lontgomery			10f. Zip Code	wne	.atov	ı	10g. Citizen of	What Cour	1 ☐ Yes 2 X No
h with ns 23a nust b	neral	2036	Henderson Ave	enue			2090	02			u.s	•
or iter miner	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ N			1	Vas Decedent of His f Yes, specify Cubar	n, Mexican,	in? (Spe , Puerto	cify Yes or No- Rican, etc.)		ce - Americ ck, White, e	
ours af		3 💢 Widowed 4 □ Divord	lf Yes, Give Year or Dates.			Yes 2 X No				Specify		White
in 72 h e. nan "na e Medic	Completed		ghest grade completed)	5+)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		of worki	ng	16b. Kind of E	usiness/Ind	dustry
ed with Hygien other tl ent, the	BeC	17. Father's Name (First, Middle				Legal Se			(Eirst Middle	G Maiden Surnam		l Law
should be filed within 7 and Mental Hygiene. 7 is marked other than raumatic event, the M	욘		William Leach	'n			TO. WIOLITE	i s i vai i		tty Lev	,	
		19a. Informant's Name/Relation	onship (Type, Print) unn - Daughte	7		ig Address (Street a Henders Ov						
permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition	on 3 Removal from State	20b. Pl	ace of Dispo	sition (Name of natory or other place			Date	20c. Location		
nit. Page 1 artment of hortant: If ite injury or of		4 ☐ Donation 5 ☐ Othe  21. Signature of Funeral Service	er (Specify)	Jude	ean Me	morial Gr	idns (					
permit. Departn Importa any inju		· Aumili	ullun	/233	ا ا	800 New t	s of Facility Iamps 1	ure	es-Rina Ave.,S	ldi tun ilver S	eral pring	Home, Inc. , MD 20904
N	П	23 Part 1. Enter the J sease, shock, or heart finlure. List	, or complications that caused st only one cause on each line	ė.				ardiac o	r respiratory am	rest,		Approximate Interval Between Onset and Death
Physician/ Medical	П	disease or condition resulting in death)	a. Conge	estiv ( a conseque	z Hear ence of):	t Failure	2	_	-	( M	6 P	m
Examiner	Jeř	Sequentially list conditions,	b. Atric		brilla	tion		_		Million State		
executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C					1	1 fle			
		resulting in death) Last	Due to (or as	a conseque	ence ot):	2/2	D 3 1	4	9	1541	17	
eath certificate be attending physic I for use as the bi	/Med	IF FEMALE:				130				V		
requires that the death certificate be been signed by the attending physic should be detached for use as the b	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🎗 No	4 🔲 Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/				ate of delive onth	ery Day Year
requires that the des been signed by the s should be detached		9 Unknown Part II. Other significant cond	9 Unknown	out not resu	Iting in the u	nderlying cause give	en in Part I.		23e Did to	phacco use cont	ribute to th	ne cause of death?
quires the	ed by	Left Hip Fi										oably 4 🗆 Unknown
has bei	Completed		Instability						24a. Was autop	sy	prior to cor	osy findings available mpletion of cause of
an; The rificate rtor, pag	Be Co	Dementia 25. Was case referred to medic	pal		<del></del>	26. Pla	ce of Death	n (Check	1 🗆 Yes		death? 1  Yes	2 🗆 No
Physici this ce ral direc	욘	examiner? 1 X Yes 2 No  27. Manner of Death	Hospital: 1  Inpati		R/Outpatien		4 A Nui			lence 6 🗆 Oth		
en ding eath. ir After h fune	icate	1.□ Natural 5 □ Pen 2 Accident Inve	nding (Month, Day estigation 08/25/2	y, Year)	injury	28c. Injury work? M 1 🗆		No	Fell	ow injury occurr out of	Bed	
or After de Di ecto	Certificate		28e. Place of Inju- building, etc	c. (Specify)					28f. Location (S	treet and Numb	er or Rural	RMD, Nu20860
To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director After this certificate has I completely filled ir by the funeral director, page 2 or	Medical	29a. Certifier 1 X Certify: (Check 2 Medical	ing Physician: To the best of at Examiner: On the basis of e	mv knowle	dge, death o	g Home	, date and p	olace, an	d due to the ca	use(s) and man	ner as state	andy Sprin
o the H //thin 24 o the F complet	Me	only one) 3 Certify  29b. Signature and title of certi	ing Nurse Practitioner: To the	e best of m	y knowledge,	death occurred at the	e time, date	e and pla	ce, and due to ti	nd place, and du ne cause(s) and r 29d. Date signe	manner as s	tated.
F > F 0		Mulyn 30. Name and address of perso	Nemes	4	MD		35791	1				, 2012
1			on who completed cause of s y, M.D., 9801				Sil	Non	Spring			
Sta							, 500		Spreeng	, morga		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John F. Brown 2012 Medical 4a. Facility Name (if pot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ESSEX iverview If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year) 216-16-1211 1 🛛 M 2 □ F 87 Director 01/23/1925 MD Usual Residence of Decedent show 10d, Inside City Limits at 10a. State 10c. City. Town or Location with the Maryland Director notified 1 ☐ Yes 2X No 28a-f MD Baltimore Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21221 1913 Old Eastern Ave USA "natural", or items idical Examiner mu death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Armed Forces?

1X Yes 2 \( \sqrt{No}\)

If Yes, Give
Year or Dates. 1942-47 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Completed 3 ▼ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) City Worker Inspector Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles R. Brown Nettie Beyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Auth Agent1610 Gray Place Dundalk MD 21222 Salvatore Serio 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State Atlantic Crem 8/28/12 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** sequentially list sendificus, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examin and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2X No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R166662

DHMH 17 Rev 06-2011

State Registrar

Eastern Ave Essex, MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Lame

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g930 8-30-12 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month S 30PM Physician/ 9 Margaret Gladys Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Future Care Charles Street Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 218-22-1671 84 **Director** 1 □ M 2 🔀 F 6, 1928 USA eb unk. Usual Residence of Decedent 28a-f show oc. City, Town or Location Baltimore 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State MD Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3915 Callaway Ave. Apt. #704 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married b Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: SpecifyBlack 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Fort Mead permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatin except. Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Be r. Father's Name (First, Middle, Last) Garland Price 18. Mother's Name (First, Middle, Maiden Sumame) Pearl Wise ည 19a. Informant's Name/Relationship (Type, Print)
Theresa Clark/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 Druid Hill Ave Balto., MD 21217 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other plan Garrison Forest 1 KBurial 2 Cremation 3 Removal from State 8/11/12 Dwings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 21223 2700 Edmondson Ave. Balto., MD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ed by the a detached i 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death?
1 Yes 2 No has page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants and the Funeral Directors. 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death Certificate; 28d. Describe how injury occurred injury 1 Natural 5  $\square$  Pending 2 Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat are and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Month 24, 201 8:41 AM ernon tuqust Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Keuin Kow 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 207 Month: Hours 1 ■ M 2 □ F 81 Director Yrs Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified fimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 1237 Kevin 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Completed 3 Widowed 4 Divorced er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Gind of Business/Industry L (Give kind of work done during most of working life. DONO) ase retired) par College (1-4 or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Fathe s Name (First, Middle. ဂ ola soone 19b. Mailing Address (Street and Number Kevin Koad *ltimore* Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stat Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ervices nature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury signed by the attending physician and detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Hospital or Attending Physician; The I 24 hours after death. 2 🗌 No 1 Tes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred iniury 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

8:41am

Registrar's

:15P				e or Print in B						egible	).
			1 - For State Registrar	tate of Maryland		irtment of <i>tificate of</i>		Mental Hy	/giene Reg. No. 2	011	2 27777
2 TOD	Physicia Medi		1. Decedent's Name (First, Middle, Last)	•				2. Date of De Month	eath	Year	3. Time of Death
2012	Examir		4a. Facility Name (if not institution, give sheet 1603 Front Ave.	and number)		4b. City, Town, Luther	or Location of Dea		4c. Cou	nty of Dea	ath
22,	Funeral Director		5. Social Security Number 6. Sex 1 \( \text{ M} \)	2 F 7. Age (In yrs. lass	- "	If Under 1 Yea Months Day:		8. Date of Bi (Month, Da	rth av, Year) 4 23	g. Bi Ok	rthplace (State or Foreign ountry) Lahoma
Aug.	ryland -f show ied at	ctor	Usual Residence of Decedent  10a. State  10b. County		Town or Loc						10d. Inside City Limits
DOD:	n the Mar a or 28a be notifi	<b>Funeral Director</b>	10e. Street and Number	re Lu	the	10f. Zip Code			10g. Citizen	of What C	1 🗆 Yes 2 🖳 No ountry?
Д	eath with	uner	11. Marital Status 12. W	/as Decedent Ever in U.S.	13 M	as Decedent of	43 Hispanic Origin? (S	nacify Vos or No.	144.5	USA	
Cage <b>036</b>	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 2 Married 1	rmed Forces?  Yes 2 Tho Yes, Give ear or Dates.	If	Yes, specify Cul	ban, Mexican, Puer	to Rican, etc.)	1.74.1	Black, Whi	erican Indian, te, etc. white
1ia 215-0	72 hour an "natul Medical	Completed	15. Decedent's Educatio (Specify only highest grade con	nn npleted)	(Give ki	ent's Usual Occu ind of work done NOT use retired	during most of wo	rking	16b. Kind o	f Business	Industry
Virginia and 21215	ed withir Hygiene other tha	Be Co	Elementary/Seconday (0-12)  17. Father's Name (First, Middle, Last)	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Homer		· 		Own		
Ví rylan	should be filed and Mental Hyy 7 is marked oth raumatic event,	101	Faye Brink Pricket					me (First, Middle, aret McG		vme)	
Virginia Ca Baltimore, Maryland 21215-0036	and 2 sho Health and tem 27 is r		19a. Informant's Name/Relationship (Type, Pri Ginny Becker/daughte	· 1.			t and Number or Runt Ave.,				
more	Page 1 annent of Hant: If ite		20a. Method of Disposition  1	val from State cem	netery, crema	ition (Name of atory or other plant 1 Nat 1.		Date 22,	20c. Location	-	Town, State
Balti	permit. Departri Importa any inju	1	21. Signature of Funeral Service Licercee  Michael J. Flagle		22. Le	Name and Addr	ess of Facility ineral Ho	me of Du	laney	Valle	ey, Inc.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final	ns that caused the death. Is on each line.	Do not enter	ne mode of dy	1	or respiratory ar	rest,	2109	Approximate Interval Between
	Medical Examiner		disease or condition	Due to (or as a consequen	ice of):	gry	home				and Death
		iner	cause. Enter Underlying	Due to (or as a consequen	ce of):			<u> </u>			
	executer an and rial-trans	l Examiner	Cause (Disease or linjury that initiated events c	Due to (or as a consequen	ce of):						
3760	ficate be g physici as the bu	Medica	d								-
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	ves, outcome of pregnancy Live Birth 2 Fetal do Pregnant at time of dea Unknown	eath 3 🗌	Ectopic pregnar Other <i>(specify)</i> _	ncy			Date of de Month	livery Day Year
s, P.O.	res that t signed by	م ا	Part II. Other significant conditions contribut	ing to death but not resulti	ng in the un	derlying cause g	iven in Part I.		obacco use co		the cause of death?
Division of Vital Records,	law requi ias been s 2 should	Completed						24a. Was autop	an 24b	. Were au	topsy findings available completion of cause of
I Re	in: The lificate h		25. Was case referred to medical					1 Yes	rmed?	death?	s 2 110
Vita	nysicia nis cert direct	To Be	examiner?  1  Yes 2 No Hospita	l: 1 ☐ Inpatient 2 ☐ ER.	/Outpatient	104	Place of Death (Che	lome 5 Resid	dence 6 🗆 O	ther (Spec	(fu)
) of	ling Pt		27. Mann of Death  1 Natural 5 ☐ Pending		b. Time of injury	28c. Inju wor	ry at	28d. Describe h			y)
Sior	Attend r death ector: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	. Place of Injury - At home	. farm. stree		Yes 2 No	28f Location (S	troot and Num	ther or Pu	ral Route Number.
Div	spital or lours afte leral Dire		29a. Certifier 1—Certifying Physician: 1	building, etc. (Specify)			o data and place a	City or Tow	n, State)		,
	thin 24 h	Medical	(Check 2 Medical Examiner: On only one) 3 Certifying Nurse Pract	the basis of examination an	d/or investig	ation, in my opini ath occurred at th	on, death occurred ne time, date and pla	at the time date a	nd place, and a	luo to the	and manner stated
	<b>5 3 5 8</b>		Ar Ar Ar	and		29c. Licens	3624		29d. Date sign	3/1	n, Day, Year)
	VP		30. Name and address of person who complete 200 Name and address of person who complete 200 Name and 200 Name	ed cause of death (Item 23	a) (Type, Prir	the La	there's	11- m	رو ما	002	
	State Registra		AUG 3 0 2012	ad cause of death (Item 23)	arked		1110111	, , ,	.0		

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Physic		Arvelica Jeanne	ast) Lte Chicas	Gue	vara	ertitica	ate of L	Jeath		2. Date of D	eath	Day	Year	3. Time of Death
Exam	dical iner	4a. Facility Name (If not institution, gi Joseph Richey	ve street and number)			4b. Ci	ity, Town, or	Location		L 8	1	4c. County	of Death	B) 30b W
Funera Directo		Social Security Number     6.	Sex 7. Ag	e (In yrs. i	last birthday) Yrs.	If Und	der 1 Year		er 24 Hrs.	8. Date of B (Month, D 0 8 / 1 7	irth ay Yea	873	Coun	**
aryland 9-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD			ty, Town or L									Od. Inside City Limits
vith the Ma 23e or 28e	Funeral Director	10e. Street and Number 309 South Cent	ral Ave	Ба		10f. 2	Zip Code 1202					Citizen of V		-
Baltimore, Maryland 21215-0036  Dearth. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglens. Important: If item 27 is marked other then "natural", or items 23e or 28e-1 show eny hilly or other traumetic event, the Medical Evaminar must be notified et	ed by Fune		12. Was Decedent E Armed Forces? 1  Yes 2  If If Yes, Give Year or Dates.			Was Dec If Yes, sp	edent of Hi ecify Cuba			cify Yes or No Rican, etc.)	)-	Blac	e - Americ k, White, e	an Indian,
Baltimore, Maryland 21215-0036 Permit. Pege 1 and 2 should be filed within 72 hours after appartment of Health and Mental Hygiene.  Moortent if filem 27 is marked other then "natural", on my hinry or other traumetic event, the Medical Evan my in hinry or other traumetic event, the Medical Evan	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4 or 5	+)	(Give	kind of w	sual Occupa vork done d rse retired)	ation luring mos	st of workir	ng	T	Kind of Bu		dustry
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Mary  Mary  Mac should  Mary	19a. Informant's Name/Relationship ( Jacquelinne Mo		er	19b. Maili 1 1 0	ng Addre	ess (Street a aytor	nd Numb	er or Rural Sil	Route Number	er, City pri	or Town, S .ngs	tate, Zip C	20912	
timore timent of H tent: If ite		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	C	Place of Dispo emetery, crei lanti	matory or	other place	9)	8/23	ate /12	ı	Location -	-	wn, State
Bail Permit		21. Signature of Funeral Service Licer	1h		I	'hom	asAll	lenP	A 70	90 Ri	dge			un Serv
Physician , Medica		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	End	Stage			, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
Examine		Sequentially list conditions, if any, leading to immediate	Due to (or as a b. — Due to (or as a											
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8760 lificate be ig physicie as the bu	Medica		d				19							
JEA NN足 TTE (isjon of Vital Records, P.O. Box 68760 Attending Physicien: The lew requires that the death certificate be redeath.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	☐ Fetal	death 3	Ectopic Other (s	pregnancy	<u>'</u>				23d. Date Mor	e of deliver	y Day Year
ds, P.C duires that en signed I	ed by F	Part II. Other significant conditions of	contributing to death bu	t not resu	ulting in the u	nderlying	cause give	en in Part	l.					cause of death?
JEA N // / / / / / / / / / / / / / / / / / /	Completed by									24a. Was autor perfo		pr de	ere autops for to comp eath?	sy findings available pletion of cause of
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of V Phys rrthis eral dii	<u>ان</u>	1 ☐ Yes 2 ☐ No 27. Manper of Death	1 Inpatier		R/Outpatien 28b. Time of		Other 28c. Injury	_4 L Nu		e 5 🗆 Resid				Hospice
On ( anding sath. rr: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		injury	м	work?	aı ′es 2.⊡		d. Describe h	iow inju	ry occurred	d	
Division of Vital  To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	al Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc.	(Specify)						City or Tow	n, State	e)		Poute Number,
the Hosp hin 24 hou the Fune mpletely fi	Medical	only one) 3 Certifying Nurs	sician: To the best of m iner: On the basis of exa se Practitioner: To the											
o i i i i		29b. Signature and title of certifier	ı			29	c. License r	number			29d. Da	ate signed	Month, Da	ıy, Year)
		30. Name and address of person who c	completed cause of dea	nth (Item 2	23a) (Type, P	nint)		10061	426			8.	-21-1	<b>}</b>
Sta	l e	31. Date filed (Month, Day, Year)	COMUT 3. Registrar	Bur	un f	27	lund	on A	v Ba	et Mb	21	291		
Registr		AUG 3 0 201	2 January	Jayram.	far.	May.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Driver Cale 08 2012 7:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2302 Birmingham Court Harford County Jarrettsville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Hours 218-12-4195 93 03/19/1919 Director North Carolina Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Harford County Jarrettsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2302 Birmingham Court 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fast Carolina Sanatarium LPN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Driver Mattie Batts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Birmingham Court, Jarrettsville, Maryland 21084 Mr. Jerry Cale 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 08/31/2012 Pineview Cemetery 4 Donation 5 Other (Specify) Rocky Mount, N.C. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.

Evans Funeral Chapel. & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) erebrovasc aj Medical Examiner Sequentially list conditions, if any, reaumy to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached the 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be de-23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2No 3 Probably 4 Unknown 1 Tyes Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hor To the Fune completed fi 29b. Signature and title of certified 29d. Date signed (Mont), Day, Year) 34208 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

3718 NUCRISVACE

WALSH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Adele Physician/ 1ATIANNA 2012 8 Medical ACO. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JANE LANC Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** If Under Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 1 🗆 M 2 💢 F 3 10 23a or 28a-f show 10b. County any injury or other traumatic event, the Medical Examiner must be notified at once, **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha tone OWN Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place Burial 2 remation 3 Removal from State Oderton MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate shock, or heart fallure. List only one cause on each line. Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-tran that initiated events resulting in death) Last physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Medical Certificate: To Be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an this certificate has autopsy 1 TYes Division of Vital To the Hospital or Attending Physician: within 24 hours after death, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Director: After Natural Accident injury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier 2 Medical Examinen Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Centring Wirse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of Name and address State gistrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ August Andre Carvell Carter 2012 10:15PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8752 Jarwood Road Baltimore Rosedale If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Hours Director 214-44-0533 1 XM 2 F 65 04/25/1947 Maryland item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examines must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8752 Jarwood Road 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 X Yes If Yes, Give 2 No 1 ☐ Yes 2 √No Specify: 3 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Security Agency Year Security Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Johnson Mildred Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnesta L. Carter (wife) 8752 Jarwood Rd., Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Desurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/2012 Garrison Forest Owings Mills, MD 21. Signature of Funeral Service Licenses ජිර්ප්ප්රිස් ප්රිම්ම Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death liver metastasis Priysician/ metastasis disease or condition resulting in death) Muntus Medical Examiner 13 months CINOMA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney disease 1 Yes 2 No 3 Probably 4 Unknown Cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy overnary ar 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 2 4 Nursing Home 5 Residence 6 Mother (Specify) nome (tespice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be n 24 hours after de le Funeral Directo oletely filled In by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completely f (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047105 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 4924 Campbell Blvd Svite 200 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State	partment of Health and N			07700
		Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg	g. No. 2012	27782
Physic Me	cian. dica	LAMES BUILDE HAVIS			28° 2012° ar	3. Time of Death 7:10P M
Exan		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funer	al	Stella Maris Hospice  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Timonium  ) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore	County lace (State or Foreign
Direct		400-16-1065 1 M M 2 D F 93 Yrs.	Months Days Hours Min.	(Month, Day, Yo Mar 29,	1919 Kent	rv)
and show lat		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			0d. Inside City Limits
Maryl: 28a-f otifiec	Coord London	Florida Pinnellis County Palm	Harbor			1 X Yes 2 □ No
ith the 23a or st be n	1 2	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
eath w		1601 Highland Club Lane 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 44-46-146	34684  B. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - America	an Indian
after d	Ē	1 Never Married 2 Married 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	Rican, etc.)	Black, White, e	
hours hours lical E	100	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates.  15. Decedent's Education 16a. Dec	redent's Usual Occupation	1.6	Specify: Whi	
ZTZT5-UU36 within 72 hours after giene. er than "natural", o the Medical Exam	potolamo	(Specify only highest grade completed)    Given   College (1-4 or 5+)   College (1-4 or	e kind of work done during most of work DO NOT use retired)	mg		
ING 21213-UU36 Ified within 72 hours after death with the Maryland tial Hygiene.  9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	8		fessor	e (First, Middle, Mai	Jniversity	Education
fiaryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at	Ę		•	Belle Ki		
Mar 2 shoul 1th and 27 is m	1		iling Address (Street and Number or Rura			
1 and 2 f Healt item 2		20a. Method of Disposition 20b. Place of Dis	E. Timonium Road,		Maryland  Oc. Location - City or To	21093
Page Tent o ant: If ury or		1 X Burial 2 Cremation 3 Removal from State Cemetery, cr	ematory or other place)		ichmond, Ke	
baltimore, Maryla permit. Page 1 and 2 should be Department of Health and Men Important: if item 27 is marke any injury or other traumatic.	ouce.	21. Signaturo Europa Service S	22. Name and Address of Facility MITCHELL-WIEDEFELD 6500 York Road, Ba	FUNERAL	HOME, INC.	1212
- 6		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	or respiratory arrest,	IOL VIOLO Z	Approximate Interval Between
Physician Medica			TIVE PULMONARY DISH	ESAE		Onset and Death
Examine	er	Due to (or as a consequence of):				
d sit	Examiner	Sequentially list conditions, If any earlier the Underlying cause. Enter Underlying				
xecute n and al-tran	Exar	Cause (Disease or injury that initiated events c				
ate be executed hysician and the burial-transit	dical	d				
eath certificat attending ph	/Me	IF FEMALE: 23h Was decedent prognant 23c. If yes, outcome of pregnancy	V			
eath ce	ician	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   1   Ves 2   No   4   Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	y Day Year
t the d	Physician/Me	g ☐ Unknown g ☐ Unknown				
Attending Physician: The law requires that the death certificate be executed are feath.  Froath.  Sector After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	ed by		underlying cause given in Part I.		co use contribute to the	<b>.</b> /
law rec	Completed			24a. Was an autopsy	prior to com	sy findings available ipletion of cause of
ician: The law certificate has rector, page 2			00 Bl (0) 1	performed 1 Yes 2		2 □ No
Physicia Physicia this cert	To Be	examiner?	26. Place of Death (Check ent 3 □ DOA Other: 4 □ Nursing Ho		e 6 X Other (Specify)	HOSPICE
ding Pl h. After th	cate:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work?	28d. Describe how i		11011
Atten er deat ector: by the	Certificate:	2	M 1 ☐ Yes 2 ☐ No treet, factory, office		t and Number or Rural F	Route Number,
pital or				City or Town, S		
To the Hospital or Attending within 24 hours after death. To the Funeral Director After completely filled in by the fune fune.	Medical		stigation, in my opinion, death occurred at e, death occurred at the time, date and pla	the time, date and n	lace, and due to the caus	se(s) and manner stated
6 ≥ 6 8		29b. Signature and the of certifier DNP, NP	29c. License number	A 29d.	Date signed (Month, D	ay, Year)
1241		30. Name and address of person who completed cause of death (Item 23a) (Type,			7-11	
St	ate	TRACIE L. MORGAN, CRNP 2300 DULAN 31. Date filed (Mante Denvise) 32. Registrar's Signature	EY VALLEY RD. TIM	ONIUM, MD	21093	
Regist		AUG 30 2012 Server 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1155 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Seasons Hospice If Under 1 Year | If Under 24 Hrs Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year 218-12-4265 Director SC 1 □ M 2 X F 92 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Baltimore NA MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3000 Virginia Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 X Married δ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2 XNo 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Domestic 10th Grade Home maker Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Wade Ernest Lucy Lindsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zio Code)
3000 Virginia Avenue Baltimore, Maryland 21215 Willie Davis-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other parrison Forest Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 09-05-12 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed lause (Ulsease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death,

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? P 1 🗌 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Mann 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the f only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 2012 AUG 3

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $\mathtt{P}^{\mathsf{M}}$ Louis Davis 2012 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days (Month, Day, Year) Director 238-46-6868 1 XM 2 ☐ F 78 Sept. 25,1933 Virginia r then "neture!", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Upper Marlboro 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9914 Churchill Dr. 20772 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married within 72 hours efter XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: Black Completed 3 ℃ Widowed 4 □ Divorced Year or Dates. 1955 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry if Health end Mentei Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government 12th Inspector B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Glen. Davis Virgie Vaughan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pege 1 end 2 Sonja Davis-Black/Daughter 1009 Chaff Way La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1
Depertment of Importent: if it
eny injury or or 1 D Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 09-05-2012 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Rd. Hyattsville, MD 20785 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a or Examiner Sequentially list conditions, Examine if arry, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ti e attending physicien end hed for use as the buriel-transit To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours efter deeth.

To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the funerel director, page 2 should be detached for use as the burlei-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Day cate has been signed by the a pege 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 1 No 2 1 No Yes 25. Was case referred to medica å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 📑 No 1 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best complete knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month arlos, Z, 2012 del 2:11a M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore Towson Social Security Number 8. Date of Birth (Month, Day Year) March 25, If Under 7. Age (In yrs. last birthday Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min Hours 185-32-8833 **Director** 130 M 2 - F 1931 Bolivia 81 Yrs. Usual Residence of Decedent 10b. County aţ 10a. State 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sl notified Maryland Cockeysville Baltimore 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ıral", or items 23a or Examiner must be ı United States of America 21030 Funeral 9 Dulaney Gate Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2XX Married 1XXYes 2 ☐ No If Yes, Give 1XXYes 2□No Specify: Bolivian Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland 12 Civil Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental Edward del Sordo Isabel Lopez and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Mrs. Astrid del Sordo/ wife 9 Dulaney Gate Court Cockeysville, Maryland 21030 t of Healt : If item / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Bel Air 20c. Location - City or Town, State Page 1 August 28 Burial 2XXCremation 3 Removal from State Department of Important: If any injury or Forest Hill, Maryland 4 Donation 5 Other (Specify) 2Ō12 Signature of Juneral Serv Levicen. Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Due to (or as a consequence of): Immediate Cause (Final Physician/ Bilatural disease or condition resulting in death) 5 days Medical **Examiner** unknow piration Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 60 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yes Certificate: To npatient 2 ER/Outpatient 3 DOA 10 this 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 Natural 5 Pending injury 2 Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 28 2012 address of person who completed cause of death (Item 23a) (Type, Print) Name and MO 6701 North Charles St. Baltimore Yaula Noe 21204 31. Date filed (Month, Day, Year) . Registrar's Signature State AUG 30 2012 Registrar

DHMH 17 Rev 06-2011

## Baltimore, Maryland 21215-0036

Examiner and

Box 68760. P.O. Division of Vital Records. certificate this After

within 24 hours after death.

To the Funeral Director:

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $P^{M}$ Barbara Anne Davis 08 26 2012 6:24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3492 N. Cassell Blvd Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Months 1 M 2 X F Days Hours Min Country) 218-54-7179 05/13/1950 Director 62 Ď.C Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Evans per nust be notified at 1 X Yes 2 ☐ No Funeral Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3492 N. Cassell Blvd 20678 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by If Yes Give 1 ☐Yes 2XNo Specify. Specify. 3 Widowed 4 N Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Behe ၉ Ervil Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Radtke / Daughter 3492 N. Cassell Blvd, Prince Frederick, MD 20678 permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/30/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Delete Dorota Marshall Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lespivatory /Medical Due to (or as a consequence of): Secusionally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 ☐ Other (specify) funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 **X**(No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 238 Merrimac C MON & NOW RIGHT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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Matthew Louis Edmonds	State of Maryland / Department of Health and Mental Hygiene	201	2
1- For State	Cortificate of Dooth	201	4

tthew Louis E	Edm	OndS 1- For State Registrar	State of	Maryland /	Departmo <i>Certifica</i>			Mental H			012	2778
Physicia dical Exami		Decedent's Name (Fig. 1)	rst, Middle,Last) THEW	Loui	e En	MAN	DC		2. Date of Dea Month August 23			ne of Death
		4a. Facility Name (if not 3336 Ravenwood	institution, give st		3 20	4b	City, Town, or Lo	ocation of Death		4c. County of		
Funeral Director		5. Social Security Numb	er 6. Sex		In yrs. last birt		If Under 1 Year Months Days	If Under 24Hrs Hours Min	<b>-</b>	1946	9. Birthplace Foreign N ( Country)	BTH
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number	County  2 Married 1 Divorced If y ion (Specify only If y (0-12)  Relationship (Type on remation 3	2. Was Decedent Every Armed Forces?  Yes 2  Fes, Give Year 196  Dates: 196  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)	rer in U.S.  No eted) 16a. C	13. Was In If Yes 1	Ocedent of Hispa specify Cuban, No es 2 No Usual Occupation of working life. D Oddress (Street a	Mexican, Puerto specify:  In (Give kind of 10 NOT use retion NOT u	work done ired)  (First, Middle, Note and Note a	Og. Citizen of Wha  U, S, H  14. Race - White, Specify: E  16b. Kind of Busin Manufa  Maiden Surname)  On  Deer, City or Town, Specify: Cocation Co	American Incetc.  3 L 3 C Incess/Industry  7 C + u R  State, Zip Co	nside City Limits Yes 2 No dian, Black,  K  Ing  ode) Co480
Physician /Medical sician and punial - transit	ian/Medical Examiner	23a. Part I. Enter the disfailure. List only on Immediate Cause (Final or condition resulting in Cause. Enter Underlying (Disease or injury that in events resulting in death UNPENDED  IF FEMALE: 23b. Was decedent pregr	ease, or compile to cause on each I disease death)  b. Due to cause it it is a cause it it is a cause it is a caus	tions that caused the	erosclerotic ence of): ence of):	4611 t enter the	PARIX H mode of dying, su ascular Disea	9fs. Av	r respiratory arro	St. shock, or heart	Appr Betv	y 1215 y 1215 y 1217 y 1217
Physician: The law requires that the transfer of the law requires that the first certificate has been signed by ral director, page 2 should be detach	To Be Completed by Physic	past 12 months?  1 Yes 2 No 9  Part II. Other significant  25. Was case referred to examiner?  1 ✓ Yes 2  27. Manner of Death	medical	Pregnant at time Unknown  Intributing to death but  ital: 1 Inpatient  28a. Date of Injury	e of death 5  ut not resulting  2 ER/Out 28b. T	Other	(Specify) erlying cause give 26.Place of DOA	Death (Check of	23e. Did to 1 Yes 24a. Was a autopi perfor 1 Yes 2 ponly one) g Home 5   I	bacco use contribu  2  No 3  10  24b. We sy pric med?	Probably 4 Pre autopsy fir to completing the Yes  Other: Scene	se of death?  Unknown  Indings available on of cause of  No
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: At completely filled in by the funeral parts.	Medical Certification:		determined  fying Physician: cal Examiner: On	(Month, Day,Year)  28e. Place of Injury (Specify)  To the best of my kr the basis of examin: d manner stated.	- At home, far	th occurred	actory, office build	and place, and eath occurred a	28f. Location (S or Town, St	treet and Number of ate)	or Rural Rout s stated. to the cause	(s)
311/		30. Name and address of	f person who comp				O.C.M.	E.		August 24, 20		, : Gai )
Sta Registi	_	Donna M. Vince  31. Date filed (Month, Da  AUG 3 0		32. Registrar's			Baltimore St	treet, Baltim	ore, MD 212	223		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Dav Year Month CREEY Man ar 5.45A M Medical 8 4a. Facility Name It not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balt more Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Jan 21, Days 1 X M 2 🗆 F **Director** 1942 OKTahoma 440-42-7639 70 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Maryland Harford Edgewood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 479 Winterberry Drive 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 0 à 1 Never Married 2 Married 1 

Yes 2 □ No
If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Information Technology Svstems Analvst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hester Marie Shields Wesley Vernon Eggerman is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 479 Winterberry Drive, Edgewood, Maryland 21040 Darren A. Eggerman / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State mportant: If injury ( Garrison Forest VA Cem. 9-4-2012 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Juneral Service Libertsee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part 1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he dail in E. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition erebrovas: UMKZIEZM # Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) be detached for in the past 12 months? Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 2 W N 25. Was case referred to medical **Division of Vital** the funeral director. Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred or Attending work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident Accident Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined To the Hospital or within 24 hours aft To the Funeral Di Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [ 3 [ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 8 28 12 and address of person who completed cause of death (Item 23a) (Type, Print) Bouleward, Baltimore, Maryland 21218

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I tem 26 per dyr 930 8-30-12 lyt and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Nancy Waller Fields 2012 10:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 218-40-0790 Director 1 □ M 2 🛛 F 70 July 10, 1942 Maryland Usual Residence of Decedent show filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f shov 10a, State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Bandon Ct., Unit 103 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 💢 No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important; if item 27 is marked other this any injury or other traumatic acceptance. registered nurse nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leolin P. Waller Gertrude H. von Behren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward B. Fields Jr. 4 Bandon Ct., Unit 103 Timonium, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Aug. 30,2012 Baltimore, Maryland Metro Crematory 21. Signature of Funeral Service Licenses MiltoneTiowiedeTeld Funeral Home, 6500 York Rd. Baltimore, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart faild Immediate Cause (Final Interval Between Onset and Death Physician disease or condition resulting in death) Anoxic weks Medical Examiner whemic wedes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 XXNo Other: 4 Nursing Home 5 Residence 욛 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier AUGUST 29 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W) 6701 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 FAHEY NHOL 7:08 p M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente: Baltimore Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Year) 1942 April 8, Director Maryland 213-40-0945 1 ★ M 2 □ F 70 Usual Residence of Dec 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Baltimore Towson 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 1055 W. Joppa U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", white 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Real Estate Sales Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ John Carroll Fahev Katherine Allen Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. Martha Stafford 26 Mallard Mill Run Wallingford, PA 19086 sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Aug 30,2012 Baltimore, Maryland 21. Signature of Funeral Service Aicense 22. Name and Address of FaMytchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ASPIRATION Onset and Death Physician/ 504-13 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DROPHARYNGEAL OYSPHAGIA Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) for Month Pregnant at time of death Day Year the detached 9 Unknown 9 Unknown b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performe 2 🗌 No Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Funeral Director: After this etely filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, after determined To the Hospital hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Fractitioner To the best of my however, and on the first occurred at the time date and place, and due to the cause(s) and manner stated. within 2

To the I

completed re and title of certifie 29b. Sigr 29c. License number MD De057619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES STREET PACTIMORE, MARYLAND KUBENFEUD MO MORTH 60701 JOSHUA

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

21204

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:33PM ree 1-oste Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Cheverly Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Director 1 🗆 M 2 🔀 F 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No 10e. Street and Numbe Zip Code 10g. Citizen of What Country? Funeral 20737 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 2 **N**No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: BIAK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) ministrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5023 Riverdale Rd #204 Riverdale Important: If item 27 any injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Surial 2 Cremation 3 Removal from State Waldon 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service 23a. Part 1. Enter the disease, or coshock, or heart failure. List onlimmediate cause (Final omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Physician/ CEPHALO PATHY disease or condition resulting in death) Medical Examiner Ostur PAM Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) MEDBROGE burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical

Records, Division of Vital e Hospital or Attending Phys 124 hours after death. e Funeral Director: After this letely filled in by the funeral di

To the Hospital within 24 hours a To the Funeral D

State Registrar 29a. Certifier

(Check

DHMH 17 Rev 06-2011

Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

The verly mo 2018

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	State of Mar					_		_	<b>3.</b>
		State Registrar			Cer	tificate of	Death		Reg. No	201	2 27793
Physicia	ın/	1. Decedent's Name (First, Middle, Las	•					2. Date of D		v Year	3. Time of Death
Medic	cal	ESHKOL  4a. Facility Name (if not institution, give	ALON	F	REEDM			AUGUS			
Examin	ier	7510 LEXHAM COUR'				BALTIM	or Location of De I∩RF.	eath		County of De	
Funeral		5. Social Security Number 6. S	ex 7. Age (li	n yrs. last	birthday)	If Under 1 Year	If Under 24 H		irth	9. E	Birthplace (State or Foreign
Director		210-80-7478	X M 2 D F	4	+2 Yrs.	Months Days	Hours M	in. 11714	71969	9   '	I SRAEL
at at	ا ا	Usual Residence of Decedent  10a. State 10b. County	11	0c. City, 1	Town or Loc	ation					10d. Inside City Limits
Maryla 18a-f tified	rect	MD BALTIM	ORE	BAL	TIMOR	E					1 ☐ Yes 2 🌠 No
h the la or 2	a D	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What (	Country?
th wit ms 23 must	Funeral Director	7510 LEXHAM COU		1.110	La	21244			US		
er dea or ite niner	by Fu	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No		13. V	Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	14. Race - An Black, Wh	
ırs aftu ıral", I Exar	edk	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🔀 No	o Specify:			Specify: WH	HITE
72 hou "nati edica	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give k	ent's Usual Occu ind of work done	during most of v	vorking	16b. Ki	ind of Busines	s Industry
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shou hand 7 is m rraum		19a. Informant's Name/Relationship (T				-		Rural Route Numb			
and and the Healt tem 2		PAUL J FREEDMAN/ 20a. Method of Disposition		20b. Plac		.U LEXHAL sition (Name of	M COURT,	BALTIMO Date			or Town, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	AN	SHE E	atory or other pla MUNAH — AIM	ice)	/27/2012		SALTIMO	
permit. F Departm Importa any inju		21. Signature of Funeral Service Licers		AL	22.	A LM Name and Addre	ess of Facility	SOL LEVIN			
e a m c e		101	uge			8900 REI	STERSTO	WN ROAD,	PIKE	SVILLE	, MD 21208
		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only o	plica of s that caused the ne cause on each line.	e death. [	- 1		1	.1	rrest,		Approximate Interval Between Onset and Death
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	NZ	Uhs	truche	Puln	my Vise	sl		Onset and Death
Examiner			Due to (or as a co	onsequen	ice oi):			/			
_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequen	nce of):						
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eath certificate t attending physi d for use as the b			d								
n certi tendin r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	oregnancy		Ectopic pregnan	ICV			23d. Date of d	lelivery
e deat the at hed fo	Physician/Med	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of dea	th 5	Other (specify) _				Month	Day Year
hat the ed by detac	y Ph	Part II. Other significant conditions of	ontributing to death but r	not resulti	ing in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute	to the cause of death?
uires t n sign uld be	Completed by							_ 1 🗷	Yes 2	□ No 3 □	Probably 4 🗆 Unknown
as bee 2 shor	plet							24a. Was			utopsy findings available completion of cause of
The Is	Com				_			1 Yes	ormed?	death?	
ician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Oth	Place of Death (Ca	heck only one)			
g Phys er this eral di	e: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of injury	28	Bb. Time of	28c. Inju	4 ☐ Nursing	Home 5 Res 28d. Describe			ecify)
ending eath. or: Afte	ficat	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation		ear)	injury	M 1 L	k? ]Yes 2 ☐ No		, , ,		
or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		e, farm, stre	et, factory, office		28f. Location ( City or To		Number or R	ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowled	ne death o	coured at the time	e date and place	and due to the c	auce(c) and	d manner as s	tated
n 24 h	Medical	(Check 2 L Medical Exami	ner: On the basis of exam se Practioner: to the bes	nination ar	nd/or investi	gation, in my opini	ion, death occurre	ed at the time, date	and place,	and due to the	cause(s) and manner stated
To th To th		29b. Signature and title of certifier		1	1	29c. Licens				e signed (Mon	
IM			1	10	10	Hoc	16763	8	0	8/24/	12012
, 0,		30. Name and address of person who d	completed cause of death	n (Item 23	Ba) (Type, Pr	int) Q. 1 101	·	1, 400	R.IL		10101
Stat	e	31. Date fled (Month, Day, Year)	32. Legistrar's	Signature	- 34	2 109 11	uce, su	H 1071	Juci	ing,	111 0100
Registra		AUG 3 0 20	172 Dueva	1	. 100	wed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 27793

		1- For State Ce	rtificate of	Death		Re	g. No.	
Physicia		Decedent's Name (First, Middle,Last)				Date of Death     Month	n Day Year	3. Time of Death
ical Exami	ner	Desiree Veronica Fair				August 19,	2012	1406 hrs
3		4a. Facility Name (if not institution, give street and number)	4	•	r Location of Dea	ith	4c. County of Deat	h
		852 W. Fairmount Avenue		Baltimore			N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye			h(MM/DD/YYYY) 9. Bi Forei	
Director		217-70-0588 <sub>1 M 2</sub>	56 Yrs.	Months Day	ys Hours M	<sup>in.</sup> 02/16		ountry) MD
	ı	Usual Residence of Decedent						
any		10a. State 10b. County 10c. City	, Town or Locati					10d. Inside City Limits
or thow	Ļ	MD N/A	I	Baltimo	ore			1 XYes 2 No
e Maryland or 28a-f show fied at once.	윉	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
or 2	Director	852 W. Fairmont Ave.			21201		U.S.A	•
death with the Maryland or items 23a or 28a-f sh must be netified at once		11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Wa	s Decedent of H	ispanic Origin? (	Specify Yes or No-	14. Race - Ame	rican Indian, Black,
ath v item ust b	Funeral	1 X Never Married 2 Married Armed Forces?  1 Yes 2 X No	If Ye	es, specify Cuba	an, Mexican, Puer	to Rican, etc.)	White, etc.	
ter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X N	o specify:		Specify: Bla	ack
ırs af t <b>ural</b>	d b	15. Decedent's Education (Specify only highest grade completed)			ation (Give kind o		16b. Kind of Business	
2 hor	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	- during mo	ost of working life	e. DO NOT use n	etired)	Commerci	al
36 thin 7. re. than	힏	8th Grade	1	Houseke	eeping		Cleaning	Co.
5-0036 ed within 72 tygiene. other than '	Ö	17. Father's Name (First, Middle, Last)			18.Mother's Nar	ne (First, Middle, M	laiden Surname)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be (	Wiley Fair			Ernest	ine Aik	ens	
AD 21215-0036  a should be filed with 72 hours after h and Mental Hygiene 27 is marked other than "natural", c matic event, the Medical Examiner:	힏	19a. Informant's Name/Relationship (Type, Print )					ber, City or Town, Stat	
MD 2 d 2 shou lth and h n 27 is n		Cassandra Fair(sister )	4809	Hazel	wood A	ve., Ba	ltimore,	
			Place of Disposi crematory or oth		emetery,	Date	20c. Location - City o	r Town, State
imore, MI Pages 1 and 2 s ment of Health a tant: If item 27 or other traum		TZ -	ng Par		0	8/28/12	Baltimor	e. MD
Baltimore, permit. Pages 1 an Department of He. Important: If ite		4 Donation 5 Other Specify: K L  21. Signature of Funeral Service Licensee					neral Hom	
Balti permit. Departir Importi		1 Ditiah Al. William	$\sim$ 21	40 N.	Fulton	Ave.,	BAltimore	, MD 21217
~√Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death	n. Do not enter th	he mode of dying	g, such as cardiad	or respiratory arre	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive in the cause of th	Athoropy	lorotio	Cordio		Diagona	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive A  Due to (or as a consequence of the condition resulting in death)		TELOLIC	Caruro	/ascular_	Disease _	
-		Sequentially list conditions, b						
	ner	if any, leading to immediate Due to (or as a consequence of	of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  purcht regulting in death). Last  Due to (or as a consequence or	of):					
ted I Insit	EX	events resulting in death) Last Due to (or as a consequence of	<i>31 ).</i>					
760, cate be executed physician and the burial - trans	ca	x UNPENDED AMENDED 23a, pt.	II,27,p	er me,g9	9-14	-12 sm		
760, icate be of physicial the buria	Medical	IF FEMALE: 23c. If yes, outcome of preg	do anciv				23d. Date of deliver	
		23b. Was decedent pregnant in the	_	tal death 3	Ectopic preg	nancy	Month	Day Year
Box 687 death certific the attending of	Physician	past 12 months?  4 Pregnant at time of de		her (Specify)				
m → ≥ m l	hys	1 Yes 2 V No 9 Unknown 9 Unknown		_				
at the ed by	by P	Part II. Other significant conditions contributing to death but not	resulting in the u	anderlying cause	given in Part I.		bacco use contribute to	
F, P.C		Diabetes Mellitus; Chronic Ale	coholism	n .		-	2 ✔ No 3 Pro	
v requi	Completed					24a, Was a autop		utopsy findings available completion of cause of
Reco The law cate has	Ē			<u> </u>		perfor 1 ✓ Yes 2		es 2 No
tal Recian: The certificate ector, page		25. Was case referred to medical		26.Plac	ce of Death (Che			
/ita	Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Residence 6 🗸 Othe	er: Scene
l of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	<u>P</u>	27. Manner of Death 28a. Date of Injury	28b. Time of I	njury 28c. Inj	jury at Work?		now injury occurred	
nding r: Af	ij	1 Natural 5 Pending (Month, Day, Year)		1	Yes 2 No			
Division tal or Attendi ts after death.	ica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, stre	et, factory, office	building, etc.			ural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, S	tate)	
E S D	S S	29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occur	rred at the time,	date and place, a	nd due to the caus	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination	and/or investigat	tion, in my opinio	on, death occurre	d at the time, date	and place, and due to t	he cause(s)
So S	Š	29b Signature and title of certifier		29c. Licer	nse number		29d. Date signed (M	onth, Day, Year)
		( Aralahana)		0.0	M.E.		August 20, 2012	2
		30. Name and address of person who completed cause of death (Iter	m 23a)		<del></del>		l	
		Laron Locke MD. Assistant Medical Examiner		altimore Stre	et, Baltimore	, MD 21223		
2	tate	31 Date filed (Month Day Year) 31 Registrar's Signal	ture -					
Regis		AUG 2 9 2012	ber					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 5:30 PM Phillip Grintz 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** -TIMORE AGNES HOSPITAL 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 73 **Director** 213-36-0613 1 🖾 M 2 🗆 F Dec 7, 1938 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n 10f. Zip Code 21228 USA 701 Edmondson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedon. Armed Forces? ¹ ☐ Yes 2 ☑ No ural", or iter Black, White, etc. þ 1 XNever Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 laborer construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number of Fural Fourte Number City of Taying State Zip Code) 611 Central Ave #301; Towson, MD 21204 Donna Brill - guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) in state Signature of Euneral Service Licen. 22. Name and Address of Facility State Anatomy Board ens 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine attending physician and I for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TRACT INFECTION ADVANCED 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown , TYPE I DIABETES DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy ESSENTIAL HYPERTENSION. performed? Yes 2 No MELLITUS, after death.

Director; After this certificate I 2  $\square$  No To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be of Vital examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 🛛 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division Accident Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifie

Komal K.Dang
31. Date filed (Month, Day, Year)

omal

AUG 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3455, Wilkens

D0018362

29d. Date signed (Month, Day, Year)

Ave Ste Lio, Balfimore, Md21229.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Gilbert Eleven Groomes 2012 3:25 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice Mt. Airy Frederick 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Director 213-32-4200 1**X** M 2 □ F 83 Usual Residence of Decedent Oct 16, 1928 Maryland 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Funeral Director Frederick Mt. Airy 1 Yes 2 No 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? 21771 USA 7633 Dollyhyde Rd. "natural", or iter 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced d Mental Hygiene. marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard R. Groomes Gertrude Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7633 Dollyhyde Rd; Mt. Airy, MD 21771 Doris Remines - daughter Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State nature of Euneral Service L 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he jrt failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Ner disease or condition MCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to jor as a consequence of, Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Loronary Artery 24a. Was an autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital Be 26. Place of Death (Check only one) Other: ည 6 Pother (Specify) Hospice Hus 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director, After tl 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check rithin 2 the only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier P 29d. Date signed (Month, Day, Year) 115108 2012

Registrar

DHMH 17 Rev 06-2011

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 3 0 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begible 27796 amend #2 Per Phy G930 8/30/2012 of Health and Mental Hygiene 27796

		State Registrar		Certificate of L	Death		Reg. No.	
Physic Med		1. Decedent's Name (First, Middle, Last	FRAEF	3. Time of Death				
Exam	iner	4a. Facility Name (if not institution, give	street and number)		r Location of Death		4c. County of D	Death
Funera		87 Caldwell Rd. 5. Social Security Number 6. Se	x 7. Age (In yrs. last bin	North thday If Under 1 Year		I o Data of Bi	Cecil	
Directo			2	Months Days	Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
D W	٦.	Usual Residence of Decedent				Dec 20,	1929 De	elaware
ryland -fsh	to G	10a. State 10b. County MD Cecil	10c. City, Tow	n or Location 1 East				10d. Inside City Limits
or 28s	Director	10e. Street and Number	NOTE	10f. Zip Code				1 ☐ Yes 2 ☒ No
Ind 21215-0036 filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	87 Caldwell Rd.		21901			10g. Citizen of What USA	Country?
or Ite	by Fu		12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No 1951 -	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite. etc.
O36			If Yes, Give Year or Dates. 1956	1 ☐ Yes 2 🛣 No	Specify:		Specify: W	
5-0 2 hou "natu	Bet	15. Decedent's Ed (Specify only highest grad	ucation 16a	Decedent's Usual Occup (Give kind of work done of	ation	u.	16b. Kind of Busine	ess/Industry
2121 within 7 giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retired) business ma	-	king		
land be filed view that had rice event,	을 일	17. Father's Name (First, Middle, Last) William Harland	Granf				Maiden Surname)	
Marylan 2 should be file Ith and Mental 27 is marked of traumatic eve	1	19a. Informant's Name/Relationship (Typ		. Mailing Address (Street a		eth Bail		Zin Codel
re, M 1 and 2 s of Health item 27 i		Marguerite F. G		. Mailing Address (Street a 87 Caldwell	Rd; Nor	th East,	MD 21901	
0 - 0		1 Donation 5 Other (Specify,	Removal from State cemeter	f Disposition (Name of ry, crematory or other plac	ce)	Date	20c. Location - City	or Town, State
Baltimc permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licen	Director	22. Name and Addres			omy Board timore, M	D 21201
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the death. Do n			-		Approximate
Priysiciani		Immediate Cause (Final disease or condition	Luna	Cancer				Interval Between Onset and Death
Medica Examine		resulting in death)	Due to (or as a consequence of	of):				
-	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	of):				+
ecuted and -transi	Examiner	Cause, Eliter Orleanying Cause (Disease Orlingry) that initiated events resulting in death) Last	Due to (or as a consequence of	Α.				
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ob / ou ertificate b ding physi se as the b	ğ	IF FEMALE:						
ath cel		23b. Was decedent pregnant 2 in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death		у		23d. Date of	
t the death the by the atternated for	Physiciar	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death g ☐ Unknown	5 U Other (specify)			Month	Day Year
es that signed to be det	ğ	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause giv	en in Part I.			to the cause of death?
AECOLUS, he law requires te has been sig	letec							bably 4 Unknown
TeC The law ate has	Completed					24a. Was a autop perfor	sy prior t med? death	autopsy findings available to completion of cause of ? //es 2  No
/stall	Be (	25. Was case referred to medical examiner?	ospital:	26. Pla	ace of Death (Chec		z (z No)	SS Z LINO
Physical direction	은	1 Yes 2 No	1 Inpatient 2 ER/Out		4 ☐ Nursing Ho		ence 6 Other (Sp	ecify)
tending Pleath.  or: After the funera	Certificate:	1		ijury work	rat ? Yes 2 □ No	28d. Describe ho	ow injury occurred	
DIVISION OF VITAL RECORDS, F.O. BOX 08/00 with the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
ie Hospi n 24 hou ie Funer oletely fil	Medical	I (CHECK ∠ □ Medical Examine	cian: To the best of my knowledge, der: On the basis of examination and/or Practitioner: To the best of my know	investigation in my opinior	n death occurred a	the time date an	ad place and due to the	0.001.00(0) and manage at at at at at
Vith to the contract of the co		29b. Signature and title of certifier	-06M 1	29c. License			29d. Date signed (Mor	
		30. Name and address of person who cou	mpleted cause of death (Item 23a) (T	ype, Print)	5 /5×	, /	Huy 23	20/2
Sta	ite_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	HE8AX'L	n Blu	d Of	n KIRAL	21061
Registr		AUG 3 0 2012	Denvisa S. 40	alas				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:20 AM 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health and Rehabilitation Ellicott Citu Howan 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 1 Year 9. Birthplace (State or Foreign Funeral Country) 103 217-22-9437 **Director** 1 □ M 2 □¥F Pennsylvania Aug 18, 1909 Usual Residence of Decede 28a-f show 10c. City, Town or Location with the Maryland at 10a. State 10d Inside City Limits Director ed 1 Yes 2 No Pikesville Baltimore ral", or items 23a or 28a-Examiner must be notifi MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21208 8345 Meadowsweet Rd. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 Yes 2 X No Specify: "natural", 3 x Widowed 4 Divorced Completed h and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) sewing seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Dickerson Hildred Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Cade) 8345 Meadowsweet Rd; Pikesville, MD 21208 Sherrie Kober Evans - niece Page 1 and 2 sh ment of Health a : If item 27 is or other tra 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ò Department of Important: If any injury or once. 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Si ma: e of Euneral Service Licensee Director 655 W. Baltimore St; Baltimore, MD 21201 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Ph sician atheroscleratic cardiovarcular disease disease or condition resulting in death) 1000 Medical Examiner nonic Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death be detached 1 ☐ Yes 2 ☐ Unknown a | Inknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 2 No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes Accident
Suicide after death. 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tribuel CENT R147658 -94-9015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Charia Friend
31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

6095 Marshalee Drive, Elkride MD 21075

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Charles L. Gordes Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 9306 Luray Drive Parkville Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maffetti 8, Yell 933 1 x M 2 □ F 215-30-7991 Yrs Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Parkville Maryland Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? þe 23a Funeral 21234 USA "natural", or items 23 edical Examiner must 9306 Luray Drive 12. Was Decedent Ever in U.S.
Armed Forces?

1 
↑ Yes 2 □ No Korea
If Yes, Give within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 ☐ Divorced Completed White Year or Dates If Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Truck Driver Trucking 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Catherine Unknown ဂ္ Henry Gordes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9306 Luray Drive Parkville, MD 21234 Susan C. Gordes - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09-01-2012 Maryland Moreland Mem. Park Baltimore 21. Signature of Funeral Service License Leonard J. Ruck, 5305 Harford Road Inc. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between tastatic Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe certificate Yes 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) Road 2 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH G932 10/3/2012 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26 2012 Year Physician/ AUGUST JOHN HENRY GILES 8:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEARTLAND HOSPICE HYATTSVILLE PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year)1925 251-20-1923 **Director** 1X□ M 2 □ F Yrs AUGUST 18 SOUTH CAROLINA 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f PRINCE GEORGE'S 1 Yes 2 No MD HYATTSVILLE 23a c the n 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 RIGGS RD #9 20783 USA items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No. 1944— If Yes, Giverny 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. BLACK "natural", 3 Widowed 4 Divorced Specify Completed 1946 Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) U/K College (1-4 or 5+) TRUCK DRIVER PRIVATE" Be 18. Mother's Name (First, Middle 17. Father's Name (First, Middle, Last) h and Mental H 7 is marked ot den Surname) of Health and Mental Hitem 27 is marked o မ JOHN RABB BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAE FOOTMAN/NIECE 58th AVENUE #334 BLADENSBURG, MARYLAND 20710 WILLIE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o o 1 

Burial 2 

Cremation 3 

Removal from State RIVERDALE CREMATORY 8/28/2012 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER RD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Adenocarcinoma Immediate Cause (Final Onset and Death
UNKNWN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to for as a consectioner of cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year ed by the a detached f been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of ate has k autopsy perform death? If or Attending Physician: The after death.

Director: After this certificate It Yes funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Chowd K 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St, Laurel, MD 20707 CHOWDHURY, MD; 605 31. Date filed (Month, Day, Year) AUG 3 0 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 27800 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Linda Marie Gasiorowski 2012 26. 05:33 PM August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Upland **Funeral** Months Davs Hours 172-42-4403 Director 1 □ M 2 🛭 F 62 69 Yrs Oct. 25, 1949 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Harford Jarrettsville Maryland 0 10e. Street and Numbe ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 1412 North Bend Road 21084 U.S.A. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rose Marie Miller Albert Jackson Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 North Bend Road, Jarrettsville, MD 21084 Mr. Frank A. Gasiorowski (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State August 29, Upper Cross Roads Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baldwin, Maryland 2012 21. Signature of Funeral Service Licensee Joffmay R. Testerman Evans Funeral Chapel & Cremation Services - Bel Air (M01543)3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Inter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) multiorgan system failure Medical Due to (or as a consequence Examiner Severe MRSA pneumonia Sequentially list conditions. Examine d any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rheumatoid arthritis Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 은 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funera 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 063420 Kle August 26,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sid 2. Kharal upper chesapeake Dr, Bel Air MD 21014.

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

astorauski

500

2. Registrar's Signature

India 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? u.s.A. 14. Race - American Indian, Black White etc Asian Indian 16b. Kind of Business/Industry D.C. Government 20c. Location - City or Town, State Adelphi, Maryland Onset and Death 15 uears 23d. Date of delivery Month Dav 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. August 26, 2012 1500 Forest Glen Road, Silver Spring, Maryland 20910

2012

Montgomery

0100

9. Birthplace (State or Foreign

State Registrar 29b. Signature and title of certifier

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Fraras Frasinger,

Telsimo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar Signat

DHMH 17 Rev 06-2011

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Terrance Antoni		ough 1- For State	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  2012 2780										
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Medical Exami		Terrano	ie	Ant	onio	G	ough	)	Augi	th Dust 23, 2	ay Year 2012	17:	20 hrs
		4a. Facility Name (if not in: University Hospit		e street and nun	nber)	· · · · · · · · · · · · · · · · · · ·	tb. City, Town, Baltimore	or Location of Dea	ith		4c. County of D	eath	
Funeral		Social Security Number	6. Se	ex T	7. Age (In yrs.	last birthday)	If Under 1 Y		Irs. 8. Dat	te of Birth (	MM/DD/YYYY) 9	. Birthplace	(State or
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ms 23s		11. Marital Status		12. Was Dece			s Decedent of	Hispanic Origin? (			14. Race - A	merican Ind	ian, Black,
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irs afte iural",	á	3 Widowed 4 15. Decedent's Education		If Yes, Give Year or Dates: nly highest grade	completed)		Yes 2 Vi	No specify: pation (Give kind o	f work don	e 16	Specify: 6b. Kind of Busine	) [CCC ess/Industry	
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Me all S	ToB	19a. Informant's Name/Rel	ationship (T	ype, Print )		19b. Mailing	Address (St	reet and Number o	r Rural Roi	ute Numbe	er, City or Town, S	State, Zip Co	de)
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Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or nither traun		20a. Method of Disposition  1 Burial 2 Crei	nation 3 [	Removal from		Place of Disposi crematory or oth		cemetery,	Date	/   2	20c. Location - Cit	y or Town, S	State
Baltimore, permit. Pages 1 as Department of Her important: If ite	ļ	4 Donation 5 Ott	er Specify:		K	ing Me	emoual	Hark E	3/30/	2012	Balt	more	MI
Balt permit Depart Impor injury		21. Signature of Funeral So	ryge Licens	see	11 4	22. N	ame and Addre	ess of Facility	tow	e a c	- Fun	eral	Home
Physician		23a. Part I. Enter the disea			used the death	h. Do not enter th	e mode of dyir	ng, such as cardiac		4111	shock, or heart		oximate Interval
/Medical Examiner		failure. List only one a Immediate Cause (Final di	sease a.		ınds (2) of	head (1) and	d chest (1)					Betw	een Onset and Death
		or condition resulting in de	ath) [	Due to (or as a d	consequence	of):							
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be est	dical	UNPENDED	AMENDED										
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Box 68761 e death certificate the attending phy ed for use as the b	icia	past 12 months?	1.1.1	4 Pregna	nt at time of de	ooth	ner (Specify)		ianoy		Wienia	Juj	Todi
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F, P.O. ires that the signed by is detach	Š	ratti. Outer agrilloant o	nations	contributing to	death but not i	resulting in the d	idenying caus	e giveri ili Farti.	1		2 No 3		
ords, w require s been sight	pleted								248	a. Was an			ndings available
Recor The law r cate has b	Comp								.	autopsy performe Yes 2	ed? deat	h?	on of cause of
tal Recinant The certificate ector, page	Be Cc	25. Was case referred to m					26. Pla	ace of Death (Chec				Yes	2 No
Vital Physician: this certified director,	To B	examiner? 1 ✓ Yes 2 No	, H	lospital: 1 🖊 Inj	patient 2	ER/Outpatient			ing Home			ther:	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the star death.  **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.		27. Manner of Death  1 Natural 5	Pending	28a. Date of (Month, I Aug 23, 2	f Injury Day,Year) :012	28b. Time of Ir 1634 hrs		njury at Work? Yes 2 ✔ No	28d. De Subjec		injury occurred		
isior Attend or death rector: by the	icati	2 Accident	Investigation	on 28e Place		nome, farm, stree			28f. Loc	ation (Stre	et and Number o	r Rural Rout	e Number City
Divi pital or ours afte teral Dir filled in	Certification:	3 Suicide 6 4 ✓ Homicide	Could not be determined	oe	Local Stre		,,,				e) ountview Road,		
Hospital 24 hours : Funeral etely filled		29a, Certifier 1 Certify						date and place, ar					
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical			On the basis of and manner sta		and/or investigati		on, death occurred	at the time				
	Σ	29b. Signature and title of o	ertifier	at.	/			nse number C.M.E.	GME	1	9d. Date signed		Year)
	-	Thodan	Me	Kin	J. J.L.	mec d		J. IVI. L.			August 24, 20	12	
10		<ol><li>Name and address of p Theodore M. King</li></ol>	_		- ,	,	900 W. Balt	imore Street,	Baltimor	e, MD 2	1223		
St	ate	31. Date filed (Month, Day,	(ear)	32. keg	istrar's Signat	u							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G931, 9/6/2012, WS
State of Maryland / Department of Health and Mental Hygiene 27803 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Nimrod Harris 10:50 AM 2605 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Hours 220-64-9213 **Director** 1 XM 2 □ F 55 Oct. 4,1956 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland n/a Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3005 Elm Avenue 21211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Examiner Black White etc. 9 þ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify "natural", Completed 3 Widowed 4 Divorced Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Doorman Prominade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Chalk
Shirley Clark 2 Franklin D. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Harris/mother 3005 Elm Avenue Baltimore, Maryland 21211 27 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. : 08/29/2012 Baltimore.Marvland ral Service LicenseeStephanie 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Custer 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequent of): disease or condition Medical resulting in death) Examiner NTRACTABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) 5 MONTHS CA UNG attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last COPP Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Dav Year 2 🗌 No ed by the a 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed 1 Yes 2 No Yes 2L N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 🗌 Yes ည 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral ( Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 3 0 2012 State Registrar

12-06496

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Certi	tment of Health and Mental H ficate of Death	ygiene 2012 2780
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)  Auburn Lilly Hopkins		2. Date of Death  Month Day August 28, 2012  3. Time of Death 2330 hrs
	4a. Facility Name (if not institution, give street and number) 1556 Galena Road	4b. City, Town, or Location of Death Essex	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 212−82−2321 1 M 2√2 F 48	t birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Maryland
ow any	Usual Residence of Decedent	own or Location Essex	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number 1556 Galena Road	10f. Zip Code 21221	10g. Citizen of What Country? United States
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If I filem 27 is marked other than "natural", or items 33a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Race - American Indian, Black,
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	21 of Dates:	6a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti	vork done 16b. Kind of Business/Industry
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than turnatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) Brooks Peele	18.Mother's Name Honor	(First, Middle, Maiden Surname) Davis
MD 21 12 should th and Me 1.27 is ma Umatic cv	19a. Informant's Name/Relationship (Type, Print )  Daniel Hopkins / Son	2915 Hudson Street, B	Rural Route Number, City or Town, State, Zip Code) altimore, Maryland 21224
	1 Burial 2 X Cremation 3 Removal from State cre		30/2012 Baltimore, Maryland mation Society of Maryland In
Physician	23a. Part I. Inter the disease, or combleations that caused the death. D failure. List only one cause on each line.	299 Frederick Road	, Baltimore, Maryland 21228 r respiratory arrest, shock, or heart Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Liver Cirrhosis  Due to (or as a consequence of):		Death
ted insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes or highly that inflated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.		
D, be executed sician and nurial - transit		,27,per me,g933 11-29	-12 sm
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buellocal Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnant 1  Live birth 4  Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna	23d. Date of delivery ncy Month Day Year
	Part ii. Other significant conditions contributing to death but not rest Chronic Alcoholism	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be detailedical Certification: To Be Completed by			24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
f Vital Physician: or this certif ral director, To Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 E	26.Place of Death (Check R/Outpatient 3 DOA Other Mursin	only one) g Home 5 Residence 6 ✔ Other: Scene
ion of tending Ph eath.  to After i the funeral ation: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 228a. Date of Injury (Month, Day, Year)	8b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurred
Division or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune funeral edical Certification:	3 Suicide 6 Could not be determined Specify)  28e. Place of Injury - At hom (Specify)	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Box within 24 h To the Fun completely	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.		it the time, date and place, and due to the cause(s)
D L 2 L 2	29b. Signature and title of certifier Throdose M. King Thu	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 29, 2012
16		aminer 900 W. Baltimore Street, B	altimore, MD 21223
State Registrar	31. Date filed (Month, 94) (Gar) 32. Registrar's Signifuge	Kal	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lee Hickey James August 08:15 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) GA 7. Age (In vrs. last birthday) **Funeral** Hours 04 Month, Day, Year) 41 254-58-1440 Director 1 **X** M 2 □ F 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 Yes 2 □ No MD NA 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 604 Winans Way · death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 Narried 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Black 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other tranmation. Future Care Elementary/Secondary (0-12) College (1-4 or 5+) 5yrs+ Pastoral Counselor Nursing Home 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Mae Seals David Hickey Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Winans Way, Baltimore, Md 21229 Francine Hickey-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 9/1/2012 King Memorial Park Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respitory disease or condition Acute Medical resulting in death) Due to (or as a consequence of): **Examiner** Encepha Anonuc Sequentially list conditions, if any, locality to in reclaim cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of Huberteneive
Due to dr as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Dav Year Pregnant at time of death the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Sleep 24a. Was an Apnea page 2 s has autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X** No ျင 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 2 Accident
3 Suicide Investigation filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Meenakehi P- 26615 08/27/12

DHMH 17 Rev 06-2011

State

Registrar

James

BALTIMORE.

MD -

21229

CATON AVE,

32. Registra's Signar re

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

DAGAR

AUG 3 0 2012

31. Date filed (Month, Day, Year)

			For State Registrar	State of Mary	land / Depa	artment of F	Health and N Death	Mental Hyg	iene 20	12 27806	
	Physicia	in/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death 10:40 PM	
and a long	Medi Examir		Gloria Jean Hende 4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Death	August	4c. County o		
No. of			Stella Maris  5. Social Security Number 6. Sex	7 And fine	um took hinkhadaya	Timoniu		Lanceton	Baltimore		
	Funeral Director			g= ()	775. last birthday) 62 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)	
	show at	ا ا	Usual Residence of Decedent  10a. State 10b. County	100	: City, Town or Lo	cation		April 2	, 1950	Maryland  10d. Inside City Limits	
	Maryla 28a-f s otified	Director	MD Baltimo	re	Reister	stown				1 Yes 2 No	
	vith the 23a or st be n	ralD	10e. Street and Number 12334 Bonmot Pla	ce		10f. Zip Code 21136		1	0g. Citizen of WI	hat Country?	
	death v items ner mu	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spanic Origin?)	ecify Yes or No-		- American Indian,	
036	s after ral", or Examir	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		Yes 2 X No		riioari, cio.j	Specify:	, White, etc. <b>White</b>	
15-0	72 hour "natul edical	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Give F	lent's Usual Occupa	ation during most of work	ing	16b. Kind of Bus	iness/Industry	
21215-0036	within 7 giene. er than the M		Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	NOT use retired) ilroad			trans	portation	
Maryland	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last) Anthony Ferdinane	do Aquilano	• • •		18. Mother's Nam Eunice	e (First, Middle, M Irene U			
, Mary	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Î	19a. Informant's Name/Relationship (Typ Lisa Henderson –	e, Print) daughter	19b. Mailin	g Address (Street a 334 Bonmo	and Number or Rura t Place;	Reister	City or Town, Sta S <b>COWN</b> ,	tb <sup>zi</sup> 21136	
Baltimore,	Page 1 ar ment of He tant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ② Donation 5 ☐ Other (Specify)	Removal from State		sition (Name of natory or other place	e)	Date	20c. Location - C	City or Town, State	
Balt	permit. Depart Import any inj		21. Signatur - Funeral Servio: Licen	of Virect	or 22	Name and Addres			-	d MD 21201	
	ANNUA SA CITA DE		23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		r the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death	
,	'hysician Medical Examiner		disease or condition resulting in death)	Due to (or as a cons							
	cxammer	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	seculence off:						
	ransit	Examiner	cause. Enter Underlying Cause. (Disease or Injury that initiated events								
09	cate be executed physician and s the burial-transit	dical E	resulting in death) Last	Due to (or as a cons	sequence of):						
6876	ertificat ding ph se as th		IF FEMALE:	Bc. If yes, outcome of pre	agnanov	-	3100				
. Box	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans!	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 😿 No g ☐ Unknown	1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	У		23d. Date Mont		
s, <b>P.</b> 0.	irres that ti signed by lid be deta	by	Part II. Other significant conditions con	tributing to death but not	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	1.2	ute to the cause of death?	
cord	aw requas beer	Completed						24a. Was an	24b. We	ere autopsy findings available or to completion of cause of	
Re	sician: The law is certificate has the law is certificate has the lirector, page 2 s		25. Was case referred to medical					perform 1  Yes 2	ned? de	ath? □ Yes 2 □ No	
Vita	nysician: nis certific I director,	To Be	examiner?	ospital:	P ☐ ER/Outpatient	Othe	r: 4  Nursing Ho		nce 6 🗶 Other	(Specify) HOSPICE	
Division of Vital Records,	r hospital or Attending Physician: 24 hours after death. Fundral Director: After this certifica etely filled in by the funeral director,		27. Manner of Death  1   ↑ Natural  2   Accident Investigation	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injury work? M 1 🗆	at	28d. Describe hov			
Jivisi Sivisi	al or After of a safter of a linector in by the control of the con		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,	
_ ;	lo the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check 2 L Medical Examine	ian: To the best of my kr r: On the basis of examin: Practitioner: To the best	ation and/or investi	gation, in my opinior	n, death occurred at	the time, date and	place, and due to	the cause(s) and manner stated.	
	Io the within 2 To the comple		29b. Signature and title of certifier	CANP		29c. License	number 2192	29	8/20/3	Month, Day, Year)	
			30. Name and address of person who cor				TIMONIUM,	MD 2100	93		
	Stat Registra	-	31. Date filed (Month, Day, Year)  AUG 3 0 2012	32. Registrar's Sig	anaturo			, .w 210.			
				, , , , , , , , , , , , , , , , , , , ,				_			

10:40 p.m.

AUGUST 19, 2012

GLORIA HENDERSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per med cert G930 8/27/12 dk
State of Maryland / Department of Health and Mental Hygiene 20 Amend 24a, 25, 26 per med cert & 29c G930 8/30/12 dk

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 2012 Robert Lewis Hicks 12:13 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3911 Bayside Drive Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 89 **Director** 225-34-6546 1 🖾 M 2 🗆 F Sept 19, Virginia Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Edgewater Anne Arundel 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21037 USA 3911 Bayside Dr. 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1942-Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white "natural", 1946 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) **USAF** security agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flora Elice Lewis Vernon Jackson Hicks Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 Bayside Dr; Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Jean Hicks - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Funeral Servi Ronald 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ eart Medical resulting in death) Due to (or as a consequence of) Examiner 5 years Dementia Sequentially list conditions, if any, leading to immediate dates. Enter Underlying Examiner Due to (or as a consequence of) the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be as IE FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Box ( Ď in the past 12 months? Month Year 1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? or Attending Physician: The Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse/Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and 29c. License number D51819

State Registrar DHMH 17 Rev 06-2011 s-ite 201 Annupuks

21401

132 Hulidan

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AUG 27

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>□</sup>17 2012 BENNIE AUGUST HOLLOWAY 2:18 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 **X** M 2 □ F Days Hours (Month, Day, Year) 83 Country) 249-40-2064 28 Oct 1928 South Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Capitol Heights 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5204 Doppler St 20743 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1952 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private Plumber | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dolan Holloway Catherine Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Holloway/Wife 5204 Doppler St. Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Arlington Nat'l Cem. 9/12/2012 4 Donation 5 Other (Specify) Arlington, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Rd Hyattsville, MD 20785 23a. Part 1/Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart fellure. List only one cause on each line. Immediate Cause (Final Onset and Death G.I. BLEED disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease Or i that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year a | Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

and

physician

the

signed by

page 2 should

funeral

filled in by the

24 hours

within 2.

the

Hospital or Attending Physician; The law requires that the death certificate be exec 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician ar

Division of Vital Records, P.O. Box 68760

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

or 28a-f show notified at

er than "natural", or items 23a or the Medical Examiner must be

than

1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other t

item 27

other

Important: If it any injury or o Department of

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with

hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine Physician/Medical δ Completed Be

Certificate: To

Medical

25. Was case referred to medical

29b. Signature and title of certifie

2 🗓 No

5 Pending

Medical Englishing Nu

Investigation 6 Could not be

1 🗆 Yes

27. Manner of Death

1 🔀 Natural

☐ Accident

4 Homicide

29a. Certifier (Check

Suicide

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No

1 ☐ Yes 2X ☐ No 3 ☐ Probably 4 ☐ Unknown

2 🗌 No Yes 26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Other:

work? 1 ☐ Yes 2 ☐ No

D61073

28c. Injury at

29d. Date signed (Month, Day, Year) AUGUST 20, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6400 MARLBORO PIKE DISTRICT HEIGHTS, MARYLAND MICKEY 0. MILLS M.D. 31. Date filed (Month, Day, Year)

State Registrar 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the heat of my linew

28b. Time of

injury

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMORTUS] Physician/ Otis Edward Holman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) Months Hours **Director** 579-40-2465 1 🕅 M 2 🗆 F 80 Yrs. Jan. 29,1932 Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Prince George's College Park 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be items 23a Funeral 6100 Westchester Park Dr. #813 20740 USA death \ 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after 1952 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Government <u>Records Examiner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Edward Holman Leanna Dockery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Barbara J. Holman/Wife 6100 Westchester Park Dr. #813 College Park, MD20740 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 08-31-2012 4 Donation 5 Other (Specify) Washington, D.C. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Rd. Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Aure Due to (or as a consequent of): INFARLTICK Medical Examiner Hypertension Sequentially list conditions, if any, reading to infine date cause. Enter Underlying or as a consequence of Exami Cause (Disease or injury PERMPINEMIA ng physician and as the burial-tran that initiated events resulting in death) Last or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 DIABUTUS mille no attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Po Pregnant at time of death Month Day Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTUE Completed 24b. Were autopsy findings available prior to completion of cause of death? MOCHOCARCHICH has performed' 2 Ho Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 - No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after dean.
ral Director: After time.
hv the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natura injury 5 Pendina Investigation \_\_ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 417 D55559 40005T 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar MASUEN

31. Date filed (Month, Day, Year)

SURA SEARCE

7525 GREENWAY

32. Registrar's Signature

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Rayvonn C. Hal	I	Sta	te of Maryland				nd Menta	al Hygiene		201	2 278
		1- For State Registrar		Certific	ate of Dea	th			Reg. No		2 210
Physici		1. Decedent's Name (First, Middle,	Last)					2. Date of D		Year	3. Time of Death
Medical Exami	ner	Rayvonn Charl		_				Month August	18, 20	12	0900 hrs
		4a. Facility Name (if not institution, 3604 65th Avenue	give street and number)			, Town, o dover H	r Location of Hills	Death	- 1	c. County of Death Prince George	
Funeral		5. Social Security Number 6	. Sex 7. Ag	e (In yrs. last bir	thday) If Un	der 1 Yea	ar If Under	24Hrs. 8. Date of	Birth (MN	//DD/YYYY) 9. Bir	thplace (State or
Director		219-23-9453	IX M 2 F	23	Yrs. Mon	ths Day	ys Hours	Min. Sept.	. 3,	1988 Foreig	n Maryland
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15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f ahd t, the Medical Examiner, must be notified at once		17. Father's Name (First, Middle, La						Name (First, Middle		n Surname)	
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ti Par		4 Donation 5 Other Spec	cify:	River	dale Cr	emat	OTA I				Home, Inc.
Baltimore, I permit. Pages I and Department of Heal Importment: If item injury of other tra	-	21. Signature of Fatheral Service Li	censae					er Rd. Hy			
Physician	_	23a. Part I. Enter the disease, or co	mplications that caused	the death. Do no							Approximate Interval
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Box 68760, e death certificate be the attending physici of for use as the buri	×	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcon		Fetal death	n 3	Ectopic r	pregnancy	23	Bd. Date of delivery Month	) Day Year
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BOS e death the att	ysi	1 Yes 2 No 9 Unkno	9 Unknown		Other (sp.	_					
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of Vital Records, P.O. in Physician: The law requires that the After this certificate has been signed by inneral director, page 2 should be detach	d by	Obesity						1 \	es 2	✓ No 3 Prob	ably 4 Unknown
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Division tal or Attendi rs after death	Certification:	2 Accident Investig 3 Suicide 6 Could r	28e Place of Ini	ury - At home, fa	arm, street, factor	y, office b	building, etc.			and Number or Ru	ral Route Number, City
Divisi pital or At ours after d neral Direct filled in by	E	4 Homicide determi						or Town	, State)		
Div the Hospital or hin 24 hours afte the Funeral Dir npletely filled in		(Ollow olly	sician: To the best of my	•			-				
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical		ner:On the basis of exar and manner stated.	nination and/or i	nvestigation, in m	ny opinior	n, death occu	irred at the time, da	te and pl	ace, and due to the	e cause(s)
HSHS	ž	29b. Signature and title of certifier	$\cap$		29	c. Licens	se number			Date signed (Mor	oth, Day, Year)
		( Aprilate	ell)			O.C.	M.E.		Au	gust 19, 2012	
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*	1		istant Medical Exa		W. Baltimor	e Stree	et, Baltimo	ore, MD 21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

			For State Of IVI	arylanc		tificate of		ind Mental H	ygien Reg. N		2 21011
			Decedent's Name (First, Middle, Last)		_			2. Date of D	eath		3. Time of Death
	Physicia Medio		Charles Warner Hall, J	r.				August	2 2 2	2 Year 2 0 1 2	2:00 aM
	Examin	er	4a. Facility Name (if not institution, give street and number)			4b. City, Town,	or Location o	f Death		c. County of Dea	
1			1366 McDonald Road  5. Social Security Number   6. Sex   17. Age	/Im um Ina	at bieth doud	Shady S		M Hrs. To Date of D		Anne Aru	
	Funeral Director		215-52-7070 13Exm 2   F	e (In yrs. Ias		Months Day		Min. 8. Date of B Min. (Month, L		9. B	irthplace (State or Foreign ountry)
		9	Usual Residence of Decedent	63	Yrs.			Aug.3	l,194	48 Mar	yland
	yland f sho ed at	to	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mar. 28a- otifi	)ire	MD Anne Arundel	Sha	dy Sic						1 ☐ Yes 2XXNo
	ith the	Funeral Director	10e. Street and Number 1366 McDonald Road			10f. Zip Code 20764				Citizen of What C	Country?
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9	or it	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married ### Yes 2 ☐	No	If	Yes, specify Cu	ban, Mexican,	Puerto Rican, etc.)		Black, Whi	
21215-0036	ural", ural",	per	3 ☐ Widowed ♣️X Divorced If Yes, Give Year or Dates.		1	Yes 2XX	lo Specify:			Specify: Wh	ite
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Maryland	should and N is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Stree	et and Number	or Rural Route Numb	er, City c	or Town, State, Z	ip Code)
	nd 2 lealth m 27		Willa M. Krider/ Sister				e., El	licott Cit	y, N	4D 21043	}
lore	ge 1 and it of H		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal from State	cer	metery, crem	sition (Name of atory or other pi	ace) A	ugust 27,		Location - City o	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Ft.		n Cemet	- '	2012 Donaldsor		entwood,	
Ba	permi Depar Impor any in	,		1053				.,Laurel,			me, P.A.
			23a. Part 1. Enter the disease, or complications that caused	the death.							Approximate
m to	toysician/		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	711	IAR	D: AI	Q'N	FORIT	10-		Interval Between O set and Death
	Medical		resulting in death)  a.  Due to (or as a	nseque	nce of):	111/6	17	1971-671			10 /1/N.
	Examiner	_	Sequentially list conditions, b.	1481	:050	Len	0515	FARITI			UNTNOWN.
	d sit	nine	if any, leading to immediate Due to (or as a cause. Enter Underlying	conseque	nce of):						
	ecute and Il-tran	Exar	Cause (Disease or injury that initiated events c	conseque	nce of):						
0	icate be executed iphysician and is the burial-transit	edical Examiner			·						
3760	ficate g physas the		G								
89	ath certific attending	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth	of pregnance	cy death 3	Ectopic pregna	ncv			23d. Date of de	elivery
Box	death ne ath ied foi	Physician/N	1 Yes 2 No 4 Pregnant at			Other (specify)	1103			Month	Day Year
P.O.	es that the dea igned by the a be detached t	Phy	9 Unknown  Part II. Other significant conditions contributing to death b	it not resul	ting in the ur	nderlying cause	given in Part I.	23e Did	tobacco	use contribute t	o the cause of death?
ري ص	res thi signer	Completed by	STROM			denying edade	g	2001.010			Probably 4 Unknown
ğ	require been si should	ete	CHRONIC	00	÷120 3	FE	2/1/11	0 24a. Wa			utopsy findings available
of Vital Records,	e law e has	duic	CARONIC	1101	17/	111	1-01	aut	opsy formed?	prior to death?	completion of cause of
E B	ysician: The la is certificate ha director, page		25. Was case referred to medical			26.	Place of Deatl	1 \(\sum Yes\)  (Check only one)	2 2 1	lo 1 ∐ Y∈	es 2 No
Vit	nysicia nis cer I direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatient	_ [0:	de e e	sing Home 5 Res	sidence	6 Other (Spe	cifv)
of	ding Ph h. After th funeral		27. Manns of Death  1 Natural 5 ☐ Pending (Month, Day (Month, Day)	y 2 ; Year)	8b. Time of injury	28c. Inj	-	28d. Describe			
ion	tendii leath. tor: Ai the fu	ifica	2 Accident Investigation			M 1	Yes 2	No			
Division	I or Attendi after death. Director: A I in by the fi	Certificate:	4 Homicide determined 28e. Place of Inju building, etc		ie, farm, stre	et, factory, office		28f. Location City or To			ural Route Number,
Ω	spital lours neral / filled		29a. Certifier 1 Certifying Physician: To the best of	mv knowled	dge, death o	ccurred at the til	me. date and i	place, and due to the	cause(s)	and manner as s	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practitioner: To the	camination a	and/or investi	gation, in my opi	nion, death oc	curred at the time, date	and plac	e, and due to the	cause(s) and manner stated.
	To the within To the Comp		29b. Signature and title of certifier	1	11	29c. Licer	se number		29d. Da	ate signed (Mon	th, Day, Year)
			Mariey & Stee	nfe	El W	0 119	D51	58	0	8/23/	2012
	5×1,		30. Name and address of person who completed cause of do		3a) (Type, Pr	rint)	61	31 51	192	150	e KD.
	O v √ Stat		31. Date filed (Month Day Year of 1990) 32. Jegistra	r's Signatu	re# 17		7 11/1	Dy 51	1/15	170	20704
	Pegietre		AUG 3 U 2012 /2000	1	J. 100	arke					

			For State	State of Maryla				Mental Hy		1.0	0701	0
			Registrar  1. Decedent's Name (First, Middle, Las	st)	Cer	tificate of D	eath	2. Date of De		12	2/81	2
н	Physicia		· Helena C. H	•				Month August	Day	012	3. Time of Death 4:45 P	
ing	Medic Examir		4a. Facility Name (if not institution, give		•	4b. City, Town, or	Location of Deat		4c. County		1.13 1	
man !			Cherry Lane Nur			Lau	rel		Prin	ce Ge	orge's	
	Funeral Director		5. Social Security Number 6. S		^	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birthp Count	lace (State or Forei	gn
			213-26-3873 Usual Residence of Decedent	□ M 2 🕱 F   8	O Yrs.			Nov. 2	9 1931	Mary	land	
	/land f sho	tor	10a. State 10b. County	10c. C	ity, Town or Lo	cation		_		10	d. Inside City Limi	is
	Mary 28a-	Director	MD Prince 0	eorge's	Laurel						1 <b>X</b> Yes 2 □	Vo
	ith the		10e. Street and Number	1 D1		10f. Zip Code			10g. Citizen of V	Vhat Coun	ry?	
	ems 2	Funeral	8476 Snowden Oa	12. Was Decedent Ever in U	.S. 13. V	20708 Vas Decedent of His	spanic Origin? (S	pecify Yes or No-	USA 14 Back	e - America	un Indian	
9	ter de , or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	If	Yes, specify Cubar	n, Mexican, Puer			k, White, e		
8	urs af tural" al Exa		3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates.		Yes 2 No			Specify:	Bla	ck	
15	72 ho n "na fedic	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give A	ent's Usual Occupa kind of work done do D NOT use retired)		rking	16b. Kind of Bu	ısiness/Ind	ustry	
212	within giene.		Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		rical			Hospi	tal		
nd	filed all Hyg d other	Be c	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname	)		
yla	uld be Ment narke	욘	Lafayette Conwa	*			Chr	isteen H	Henrahan			
Mai	2 shouth and the and the strain traum		19a. Informant's Name/Relationship (T			g Address (Street a					2104	)
ē,	and 2 s F Health a Item 27 i		Valeriese B. Rans 20a. Method of Disposition		1067 Place of Dispos		rcy Plac	e, Apt.	20c. Location -			_
m0	age nent of		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	cemetery, crem	natory or other place Valley Me		0/2012	Timoniu	,		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	see la	22	Name and Address	i	onaldsor				
ш	20 E # 9	_ 3	Janices			313 Talbo				20707		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cade on each line.  Immediate Cause (Final												
<b>4</b>	Physician Medical	1	disease or condition resulting in death)	a. Arteri		otic Card	liovascu.	lar Dise	ase		Onset and Death	_//
A PROPERTY.	Examiner				defice oi).							
-	D I	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	uence of):							
	ecutec and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	nence off.					_		$\dashv$
0	sate be executed physician and s the burial-transit	edical		d								
3760	ificate ig phy as the	Medi	IF FEMALE:	d								
Box 68	h cert tendin or use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live Birth 2 Fet	ancy al death 3	Ectopic pregnancy	,			e of deliver	•	
Bo	e deat the at thed fo	Physician/M	1 Yes 2 XXIII	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			Mor	nth [	Day Year	
Ö.	hat the	by Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the	cause of death?	$\neg$
_ S,	uires t in sign		Senile Dem	entia				1 🗆 🕆	Yes 2 X No	3 Prob	ably 4 🗆 Unknov	vn
COL	aw rec as bee 2 sho	Completed						24a. Was a			sy findings available	
Re	sician: The law certificate has b lirector, page 2 s	Con							rmed? d	eath?		
ţ	ician: certific rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:		Other	ce of Death (Che					
<u></u>	g Physer this eral di	e:	27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatient 28b. Time of	28c. Injury	4 🕰 Nursing F	lome 5 Resid	ence 6 Othe			-
ou o	ath. r: Afte re fun	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	injury	work?	res 2 ☐ No	2007 2000 120 11	on injury occurs	~		
Division of Vital Records, P.O.	or Atter fter de irecto n by tl	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifi		et, factory, office		28f. Location (S City or Tow	treet and Numbe n. State)	r or Rural f	Route Number,	
Ō	spital o	_	29a. Certifier 1 Certifying Phys	sician: To the best of my know		courred at the time	data and size			or oc -t	4	_
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 L Medical Exami	ner: On the best of my know ner: On the basis of examinations of Practitioner: To the best of	n and/or investi	gation, in my opinion	, death occurred	at the time, date a	nd place, and due	to the caus	e(s) and manner sta	ited.
	To the within Comp.		29b. Signature and title of cortifier	A	2 4 5	29c. License			29d. Date signed			$\exists$
				the -	MN. F	D2	4721		August	27,	2012	
	2		30. Name and address of person who c				200					
	Stat	e	Syed Sadig, 14: 31. Date filed (Month, Day, Year)				∠08 La	aurel, M	20708			$\dashv$
	Registra		AUG 3 0	2012 32. Reyistrar's Signa	p. 4	acked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 20°12 Lorraine Harrington 24<sup>ay</sup> 9:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 103 Chell Road Joppatowne Harford **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min (Month, Day, Year) **Director** 215-40-6051 1 M 2 X F 69 Yrs. 09/02/1942 MD show 10b. County notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f MD Harford Joppatowne 1 🗌 Yes 2 🔀 No 2 should be filed within...
alth and Mental Hygiene.
a Z7 is marked other than "natural", or items 23a c...
...matic event, the Medical Examiner must be not 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Chell Road 21085 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Teacher's Aide Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment. Important: If item 27 is marken any injury or a... George Lawrence Vontran Marie unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Harrington, Jr.-Spouse 103 Chell Road, Joppatowne, MD 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 08/28/2012 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, 610 W. MacPhail Rd., Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ BRIZAST disease or condition resulting in death) CANCR Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir Hospital or Attending Physician; The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical P.O. Box 68760 as the attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ó in the past 12 month 1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available has te 2 prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page performe certificate Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) nours after death. neral Director: After the filled in by the funera 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after To the Hospital within 24 hours a To the Funeral C completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0058475 PHYSECEAN 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INTW, 510 UPPIZACHTZAPARKIZDI BIZL PHELEPNEVAT

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MARY LYNN HARVEY 26,2012 10:06 P.M AUGUST Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON BALTO. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-7-1958 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 214-72-6452 Director 1 M 2 X F 54 MARYLAND shov ie 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. It of Health and Mental Hygiene. If item 27 51 marked outher then "natural", or items 23a or 28a-f sho of other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD. BALTO. PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9603 AMBERLEIGH LANE APT.M 21128 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) BALTIMORE CO. GOVERNMENT College (1-4 or 5+) 12 IRECTOR OF COMMUNITY CONSERVATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES DERDA VERONICA PLOTCZYK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN G. HARVEY **SPOUSE** <u>9603 AMBERLEIGH LANE APT M</u> PERRY HALL, MD. Baltimore, 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Importent: If ite any Injury or ot Date 1 Burial 2 Cremation 3 Removal from State ATLANTIC CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 8-29-2012 GLEN BURNIE, MD. 21. Signature of Full eral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME. INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 1 23a. Part 1. Enter the disease, or complimions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) Physician/ ECTIM Concer Medical Du to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed physicien end s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 1 Yes 2 No 5 Other (specify) Day Year Pregnant at time of death ed by the a a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 ☐ Yes 2 No Hospital or Attending Physician: **Division of Vital** 8 25. Was case referred to medical 26. Place of Death (Check only one. Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this c 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 2 Accident 3 Suicide 5 Pending iniury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MARON Annes M 6701 31. Date filed (Month, Day, AUG 3 0 32. Registrar's Signature State Registrar Darke

∕iola Hower		epartment of Health and Menta Ce <i>rtificate</i> of Death	1 Hygiene Reg. No. 201	2 2781
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year  August 23, 2012	3. Time of Death 0930 hrs
wat.	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of D Bel Air		h
Funeral Director	189–07–7410 1	yrs. last birthday)   If Under 1 Year   If Under 2   Months   Days   Hours	Min	rthplace (State or gn puntry) Montana
ind show any nce.		City, Town or Location		10d. Inside City Limits 1 Yes 2 No
r death with the Maryland nr items 23a or 28a-f ab must be notified at one Funeral Director	10e. Street and Number 2016 Robertson Road	10f. Zip Code 21015	10g. Citizen of What Cou United States	
s after death wi rral", nr items nioer must be 1 by Funere	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 N  Widowed 4 Divorced of Dates:	if Yes, specify Cuban, Mexican, Pe	white, etc.)  Specify: White	
6 172 hour an "natu cal Exan	15. Decedent's Education (Specify only highest grade complete:  Elementary/Secondary (0-12) College (1-4 or 5+)  12	d) 16a. Decedent's Usual Occupation (Give kinduring most of working life. DO NOT usu		Industry
21215-0036 ould be filed within 7 i Mental Hygiene. is event, the Medica TO Be Comple	17. Father's Name (First, Middle, Last) Alex Long	Amanda		
MD 21 ad 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print)  Marjorie Lafevers (Daughter)  20a. Method of Disposition	19b. Mailing Address (Street and Numbe 2909 Woods End Drive, J	r or Rural Route Number, City or Town, State  pppa, Maryland 21085  Date   20c. Location - City or	
Baltimore, MI permit. Pages I and 2s Department of Health a Importact: If item 27 injury ar other traum	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or other place) Evans Funeral Chapel 0	8/28/2012 Forest Hill,	Maryland
	21. Signature of Funeral Service Licensee  23. Part I. Enter the disease, or complications that caused the de	13 Newcort Drive, For	& Cremation Services - Best Hill, Maryland 21050	el Air
Physician /Medical Examiner	failure. List only one cause on each line.	complicated by acute myocardial infa		Between Onset and Death
ted insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ice of):		
0, e be executed existian and burial - transit	events resulting in death) Last  Due to (or as a consequent of the	ice of):		
9 a 2 9 5	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of past 1 Live birth 4 Pregnant at time of purchased the past 1 Unknown	2 Fetal death 3 Ectopic pr	egnancy , Month [	y Day Year
IS, P.O. I quires that the en signed by that the detached ted by Ph	Part II. Other significant conditions contributing to death but n	not resulting in the underlying cause given in Part I	Yes 2 ✓ No 3 Prot	
Records, P.( : The law requires that ifficate has been signed r, page 2 should be det. Completed by	25. Was case referred to medical	26.Place of Death (Ch	autopsy prior to control death?  1 Yes 2 No 1 Yes	completion of cause of
F Vital Physician r this certi	examiner? 1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient 2	ER/Outpatient 3 DOA Other N	ursing Home 5 Residence 6 Other	r
Division of a To the Hospital or Attending Pu within 24 hours after death. To the Funeral Directur: After the completely filled in by the funeral edical Certification: Tedion 1	27. Manner of Death  1 Natural 5 Pending Investigation  28a. Date of Injury Aug 20, 2012 arr)  29a. Date of Injury Aug 20, 2012 arr)	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No.	A HITCHARD STREET TO THE OWNER OF THE OWNER OWNER OWNER OF THE OWNER O	Do to North Ch
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Suicide Could not be determined (Specify) residen		28f. Location (Street and Number or Ru or Town, State) 2016 Robertson Road, Bel Air, MD	
To the He within 24 To the Fu Complete!	(Check only	wledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occur		e cause(s)
	Coleuns	O.C.M.E.	August 28, 2012	
)	30. Name and address of person who completed cause of death ( Zabiullah Ali, M.D. Assistant Medical Examin	ner 900 W. Baltimore Street, Baltimo	ore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Sig	harlel		
DHMH 17 Rev 1/2001	nou o u zone person pe	ORIGINAL	OCME	

=	1	For State	State of N	Marylan		artmen rtificate			ınd Me	ental Hy	/giene Reg. No.	201	2	27216
		Registrar  1. Decedent's Name (First, Middle, Las	t)		- 007	incar	01 2	Jean	2	2. Date of De				3. Time of Death
Physician/ Medical	ı		mmach			,				Month	24	Year		0328AM
Examiner	1	4a. Facility Name (if not institution, give Suburban H	,	)		4b. City,		Location of Bethes			4c.	County of De		omery
Funeral		5. Social Security Number 6. Se		Age (In yrs. I	ast birthday)	If Under	1 Year	If Under 2	4 Hrs. 8	B. Date of Bi	rth	9. E	irthplac	e (State or Foreign
Director		216-50-7241 Usual Residence of Decedent	□м 2 💢 F	66	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year) 2 / 194		sountry) Shiv	igton, DC
Maryland 28a-f show otified at	5	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						<u> </u>		Inside City Limits
Mary 28a-f			omery				_	Kensi	ngtor	ı				1 🗌 Yes 2 🂢 No
Jeath with the Maryland items 23a or 28a-f she must be notifiled at Euneral Director		10e. Street and Number	enway Dri	110		10f. Zip	Code	2089	5		10g. Citiz	zen of What (	S.A	
death vitems		11. Marital Status	12. Was Decedent	t Ever in U.S	S. 13. \	Was Deced	ent of Hi	spanic Origin, Mexican,		y Yes or No-	1	14. Race - An	nerican	Indian,
after of all", or samin		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 🗌 Yes 2 🗴 If Yes, Give			Yes			Puerto Ric	can, etc.)		Black, Wh Specify:		
21215-0036 within 72 hours after giene. giene than "ratural", o the Medical Exam Completed by	2	15. Decedent's Ed			16a. Deced	dent's Usua	l Occupa	ation furing most o				nd of Busines		ucasian trv
hin 72 hin 72 ne. than "	-	(Specify only highest gra	College (1-4 or	r 5+)	life. D	O NOT use	retired)					Inter	gene	erational
id 2: Hygie other ent, th		17. Father's Name (First, Middle, Last)	4	-	V	oxuni	eer	Direct		First, Middle	Maiden S		rogi	it System
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If the 27 is makenda Hygiene with "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	2		Yale Coh	en				TO. WOUTO	o realine (r		net B	,		
Mar. Sahoul P and I		19a. Informant's Name/Relationship (Ty										Town, State, 2		
Thealt Healt other other	1	Scott Hammack -	Son	20b. F	4882 lace of Dispo			Drive	e, No			cation - City o		Land 20852
Page 1		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stat	te c	emetery, cren norah	natory or ot	her place					•		vryland
Baltimore, No permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tronce.	Ī	21. Signature of Funeral Service Licens		7 123	22			s of Facility	Simp1	e Tribu	ite Fur	neral &	Crem	ation Center cryland 20852
Ph sician/	1	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that cause	ed the deatl		er the mode	of dying				<u> </u>	Jenville	Ar	proximate
Ph_sician/ Medical	ļ	Immediate Cause (Final disease or condition resulting in death)	a. SUBDU		tomos	ion L	No	NTRA	umat	tie				terval Between
Examiner	1		Due to (or as		ence of):	5mR-	0.1	024					2	3 A 1 D 1 z
iner liner	1	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	erice of):			To the					13	MAMIN
SIZHIII		Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as		P-1735	nc >	JH.	Kint					ゴ	ともりな
Siciar burit		resulting in deathy East	d	s a consequ	crice on.									
8760 B760 B760 B760 B760 B760 B760 B760 B	-	F FEMALE:	<u> </u>											
HAMMAR K, BARBARA, P.O. Box 6876  Division of Wtal Records, P.O. Box 6876  To the Hospital or Att and Physician: The law requires that the death certificat within 24 hours after diath.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral cirector, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Mec		3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 🔲 Feta at time of d	Ideath 3 🗌	Ectopic p Other (spe		у			23	3d. Date of d Month	elivery Dag	y <b>Y</b> ear
P.O. P.O. hat the that the chart the details of P.O.		Part II. Other significant conditions co	1	but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco us	e contribute	to the c	ause of death?
ds, dulines seen signould by teed if		Told moit the h	yelons.				_		- 1	1 🗆	Yes 2	No 3 □	Probabl	y 4 🗌 Unknown
Wital Records, P. Wital Records, P. Wisician: The law requires that his certificate has been signed I cirector, page 2 should be de To Be Completed by P.										24a. Was auto perfo 1 \(\sum \) Yes		prior to death?	comple	findings available etion of cause of
ician:	2	5. Was case referred to medical examiner?  1  Yes  No	lospital:					ice of Death	(Check or					
Physic eral cin		7. Manner of Death	1 Inpa 28a. Date of inj	jury	ER/Outpatien 28b. Time of	$\overline{}$	A Othe	_ 4 □ Nurs		5 Residue 1		Other (Spe	cify)	
on o		1 Natural 5 Pending Provided Investigation	(Month, De	ay, Year)	injury	м	work?	Yes 2 N		1. Describe i	iow injury t	occurred		
Division of Division of Division of Hospital or Att. Inding P 4 hours after do att.  "uneral Director: After the filled in by the funeral dical Certificate:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	ijury - At ho tc. <i>(Specify)</i>	me, farm, stre	et, factory,	office		28f	f. Location (S City or Tov		Number or R	ural Rot	ute Number,
he Hospita in 24 hours he Funeral pletely filled		29a. Certifier 1 Certifying Physic (Check 2 Medical Examinonly one) 3 Certifying Nurse	ician: To the best of er: On the basis of Practitioner: To the	examination	and/or invest	idation, in m	opiniao ve	n, death occi	urred at the	time date a	and place a	and due to the	causels	s) and manner stated.
To t with To t com		9b. Signature and other continer				- 1	License					signed (Mon		
12		0. Name and address of person who co	ompleted cause of	death (Item	23a) (Type, P	rint)	2	BET	HEI	<b>A</b> ,	MD	208	317	
State Registrar	3	AUG 3 0 2012	32. Registr	rar's Signat	ale					7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2 Date of Death Month 8 Physician/ 550 201 Medical 4a. Facility Name (if pot institution, (£xaminer give street and number, own, or Location of Death 4c. County of Death AltiMORE N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗶 M 2 🗆 F Months Days Hours Min. 76 213-34-8051 Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 28a-f 1 X Yes 2 No Baltimore 10e. Street and Number r must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 5009 Frankford Ave. 21206 USA items 2 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Examiner Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò ģ 1 Never Married 2 Married 2 **X** No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) N/A Elementary/Seconday (0-12) Labor Worker 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Forest F. Johnson Lenora Westry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4800 Yellowwood Ave. Baltimore, MD21209 19a. Informant's Name/Relationship (Type, Print) 4800 Yellowwood Ave. Baltimore, Lenora Brown-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemt. 8/28/2012 Baltimore, MD March F/H-East 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ IUER All disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 25. Was case referred to nedical 26. Place of Death (Check only one) funeral director, examiner? Hospital: Other ဂ္ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation completed filled in by the 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29b. Signatu 29d. Date signed (Month. Day. Year.

State Registrar death (Item 23a) (Type, Print)

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		1- For State Certificate of Death Registrar						
Physici Medical Exami		MOTIO L	Day Year 1120 hrs					
		Michael Johnson August 7, 20  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death					
<i>-</i>		1807 Frederick Avenue  8altimore  5. Social Security Number 12014 6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or					
Funeral Director		5. Social Security Number unless Sex  1 Months Days Hours Min.  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth Months Days Hours Min.   May 20,						
япу	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits					
<b>≱</b> .∗		MD Baltimore	1 X Yes 2 No					
<b>215-0036</b> be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a nr 28a-f show ent, the Medical Examiner must be notified at once.		10e. Street and Number 10f. Zip Code 21223	USA					
th with ems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 XNever Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>					
ter dea ", or it			Specify: Black					
iours af istural	ed by	I or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	6b. Kind of Business/Industry					
136 thin 72 hours a ne. than "natura edical Examin	Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  9 0 stock clerk	Foo Depot					
5-00, led with tygiene other ti		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Ma						
21215-1 vuld be filed Mental Hyg marked off		Michael Deshields Johnson Sr. Emma Beard						
MD 21215-0036 11 should be filed within 7 th and Mental Hygiene. 117 is marked other than umatic event, the <u>Medica</u>	2	2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numb						
t te leal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 2	20c. Location - City or Town, State					
MOF Pages ent of int: If		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Xother Specify: in state						
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		21. Signature of Funeral Sorice Lice 29 (Director 22. Name and Address of Facility State Anato						
Physician		23a. Pal I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest	t, shock, or heart Approximate Interval					
Medical		failune. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic and Alcohol. Intoxication	Between Onset and Death					
Examiner	al Examiner	or condition resulting in death)  Due to (or as a consequence of):						
		Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):						
		C. Due to (or as a consequence of):						
ficate be executed ficate by sician and the burial - transit		五						
O, be exe	edica	x UNPENDED						
Box 68760 e death certificate b the attending physi ed for use as the bu	W/u	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year					
OX 687 eath certific attending	d by Physician/Medical	4 Pregnant at time of death 5 Other (Specify) 9 Unknown						
that the denet by the detached			acco use contribute to the cause of death?					
F. P.O.		1 Yes	2 No 3 Probably 4 V Unknown					
ords, P w requires the second of the second	plete	24a. Was an autopsy						
tal Reco	Completed	perform 1 V yes 2						
'ital sician: is certif irector,	B	25. Was case referred to medical 26. Place of Death (Check only one)  1	esidence 6 🗸 Other: Scene					
of Vii ing Physi After this	2	77 Manages of Doubth						
sion ttendin death. ctor: /	atio	The state of the s						
Division of Vital Records, ospital or Attending Physician: The law require hours after death.  Ineral Director: After this certificate has been silve filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 S Could not be determined Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 1 Specify Building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e.	eet and Number or Rural Route Number, City te) 1807 Frederick Ave.					
Hospi 24 hou Funer rely fil	Medical Cer		s) and manner as stated.					
To the within To the comple	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)					
		O.C.M.E.	August 8, 2012					
		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223						
S Regis	tate trar							
Negis	للتان	AUG 3 V CUIC MARKET PO TO						

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State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	State of Maryland		te of Death			Reg. No. 2012	2 27819
Physicia Medic		1. Decedent's Name (First, Middle, Last) SAIR LEY D.	JEN KING				2. Date of Dea	The Day 2017 ar	3. Time of Death 0745 M
Examin		4a. Facility Name (if not Institution, give s 3 405 Pt   MOVS	- PD	(1)	y, Town, or Location	of Death	1	4c. County of Deat	WE-
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last	Yrs. Month			8. Date of Birt	Year 43 Co	hplace (State or Foreign
Aaryland 8a-f show tified at	rector	10a. State 10b. County  BALTIA	10c. City,	Town or Location	MILL				10d. Inside City Limits 1  Yes 2 No
with the Ns 23a or 2	Funeral Director	10e. Street and Number 3/105 Ph.//mor.	E RD	10f. 2	21244 21244	'		10g. Citizen of What Co	untry?
Interporte, INIGINITY AND A INITY CONTROL OF The Property of and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. Ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at.	þ	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, 2 No If Yes, Give Year or Dates.	If Yes, sp	edent of Hispanic O ecify Cuban, Mexica 2 No Specify	an, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: *P/	
thin 72 hou sne. than "natu he Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT u	ork done during mo	ost of workin	ng	16b. Kind of Business	Industry
idnu 6 be filed wi ental Hygis rked other ic event, ti	To Be (	17. Father's Name (First, Middle, Last)	mavŝ		18. Mot	ther's Name	(First, Middle,	Maiden Surname)	
Maryia d 2 should be tath and Ment n 27 is marke er traumatic		19a. Informant's Name/Relationship (Type)	e, Print) (W)	19b. Mailing Addre	ess (Street and Number)	ber or Rura	Route Number	r, City or Town, State, Zip	D. 21244
Page 1 an ment of He tant: If iten		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State / cer	ce of Disposition (Netery, crematory o	ame of rother place)	9-1	1-12	20c. Location - City or	Town, State
permit. Pag Department Important: any injury o	7	21. Signature of uneral Service Lice		GARY	and Address of Faci	Fun	TO ROD	ALTEN TOS	21229 111.1110)
Physician/		shock, of heart failure. List only on Immediate Cause (Final disease or condition	ications that caused the death. e cause on each line.						Approximate Interval Between Onset and Death
Medical Examiner	J.	Immediate Jause (Final disease or condition resulting in death)  A MOTROFILE LA SUBJOS B  Onset and Death  Onset and Death  Onset and Death							
ecuted and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):							
icate be exected the private of the purial-1	edical	L.	d						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Dectop	c pregnancy (specify)			23d, Date of de Month	livery Day Year
ires that the signed by	þ	Part II. Other significant conditions con	ntributing to death but not resul	ting in the underlyin	g cause given in Par	rt 1.	23e. Did to	obacco use contribute to Yes 2 ☑ No 3 ☐ P	the cause of death?
<b>fecords,</b> he law requires te has been sig age 2 should b	ompleted						24a. Was autor perfo	prior to	topsy findings available completion of cause of
VITAL NECO ysician: The law r is certificate has b director, page 2 si	Be C	25. Was case referred to medical examiner?	ospital:	2/2 / 1/2 / 2 / 2	26. Place of De		only one)		
office V value of value of the value of the value of the value of the value of value	cate: To	27. Manner of Death  1 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing H  28a. Date of injury (Month, Day, Year)			- 2	Home 5 Presidence 6 □ Other (Specify)  28d. Describe how injury occurred		
DIVISION OF tal or Attending PI rs after death. al Director: After the ed in by the funera	Il Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		ral Route Number,		
n 24 hour le Funer	Medical	(Check 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination a Practioner. To the best of my k	and/or investigation,	in my opinion, death	occurred at	the time, date a	ind place, and due to the	cause(s) and manner stated.
To the within comp	_	29b. Signature and title of certifier	2.	2	9c. License number 04677			29d. Date signed (Monti	
4		30. Name and address of person who co	empleted cause of death (Item 2	23a) (Type, Print)		/			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re hadd					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 00:53 M Clinton nnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ) niversity of Maryland Medical Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Days (Month, Day, Year) **Director** 262-74-3566 1 X M 2 🗆 F 63 02/16/1949 North Carolina 28a-f show 10a. State If than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10595 Graeloch Road 20723 U.S.A death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African Yes 2 X No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dental Technician Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ should be William Moore Annie Lee Johnson Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Patricia Divinnie / spouse 10595 Graeloch Road, Laurel MD 20723 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 08/29/2012 Odenton, MD Signatur Ineral Service Lo-22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. Se disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine o (or as a consequence of) Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death ed by the at detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : certificate has autopsy performed? Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 🗌 Yes ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury death. Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier +017 29c. License number mysicia 205 ON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Balti 22 RVH

DHMH 17 Rev 06-2011

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 29, 2012 Ruth James 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 136 Driftwood Ct. Harford Joppa If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 213-28-7761 **Director** 1 □ M 2 🗓 F 80 April 21 1932 MD f show 10b. County d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9601 Labrador Lane 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1  $\square$  Never Married 2  $\square$  Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) n/a Electrical Inspector Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Clifford Leon Woodside Myrtle Allport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jinger James/daughter 136 Driftwood Ct., Joppa, MD <u> 21085</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 8/30/12 Glen Burnie, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael Carpenter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence or) Examir attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? \_\_ Yes b Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Daughter's Other: 4 Nursing Home 5 Residence 6 K Other (Specify) Residence 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date(signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) John Downs, M.D. 1734 York Road Lutherville, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 0 2012 Registrar

	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 20   2 27826									
	Physician/ Medical  1. Decedent's Name (First, Middle, Last)  Medical			2. D	ate of Death  Anoth  An					
	Examir		4a Facility Name (if not institution, give street and number)  AC Johns Has Kins Haspife	4b. City, Town, or Location of Death  Broken and City	4c. County of Death N/A					
	Funeral Director			Months Days Hours Min. /(N	ate of Birth Alonth, Day, Year)  9. Birthplace (State or Foreign Country)  11, 1943 New Jersey					
	aryland a-f show fied at	Director		City, Town or Location	10d. Inside City Limits					
	h the Ma Sa or 286 be notii		10e. Street and Number	Manasquan  10f. Zip Code	1 ☐ Yes 2√ No 10g, Citizen of What Country?					
	eath wit tems 23 er must	Funeral	371 Euclid Avenue  11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	United States es or No-  14, Race - American Indian,					
9800	rs after d ural", or it Examine	Be Completed by	1 ☐ Never Married 2 🔀 Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🏋 No Specify:	Black, White, etc.  Specify: White					
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry					
	ild be filed within Mental Hygiene. Iarked other tha atic event, the I		17. Father's Name (First, Middle, Last)	Art Teacher  18. Mother's Name (First	Art Education  , Middle, Maiden Surname)					
Maryland	should be and Menta is marked	υ	Robert P. Quimby		erine D. Kammerer					
	and 2 shou Health and :em 27 is m		Joan Kammerer / Wife	19b. Mailing Address (Street and Number or Rural Route 371 Euclid Avenue, Manaso						
altimore,	0 = =		1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State					
altin	in in it		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee Allyson K Ta	tro Crematory Inc 08/30/20 ay or 22. Name and Address of Facility Cremat	012   Baltimore, Maryland ion Society of Maryland Inc					
Ш	299 Frederick Road, Baltimore, Maryland 21228									
á.	Physicia V	10	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Metastasis	rratory arrest, Approximate Interval Between Onset and Death					
Medica Examine			resulting in death)  Due to (or as a consequence of):							
	sit s	Examiner	Sequentially list conditions, if any bearing to immediate cause. Enter Underlying							
	be executed sician and burial-trans									
09289	cate be physicia s the bu	edica	d							
Вох	res that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fei 1 ☐ Ves 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	tal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year					
s, P.O.	The law requires that the ate has been signed by the page 2 should be detach	þ	Part II. Other significant conditions contributing to death but not re	3e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown						
cord	w requi	Completed		2	4a. Was an autopsy findings available prior to completion of cause of					
l Re	sician: The la certificate ha irector, page 3		25. Was case referred to medical		performed? death?  Yes 2 No 1 Yes 2 No					
Vita	hysicia his certi	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: Inpatient 2 ☐	26. Place of Death (Check only	Decipone)  ☐ Residence 6 ☐ Other (Specify)					
Division of Vital Records,	nding P ath. : After t e funera	cate;	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)	28b. Time of injury 28c. Injury at work?  M 1  Yes 2 No	escribe how injury occurred					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be		ocation (Street and Number or Rural Route Number, ty or Town, State)					
_	he Hospit in 24 hour he Funera ipletely fill	Medical	(Check 2 Medical Examiner: On the basis of examination	wledge, death occurred at the time, date and place, and due on and/or investigation, in my opinion, death occurred at the time my knowledge, death occurred at the time, date and place, and	ne, date and place, and due to the cause(s) and manner stated.					
	To t		29b. Signature and title of portilier	29c. Ligense number	29d. Date signed (Month, Day, Year)					
	81		30. Name and add/ess of person who completed cause of death (Iter	m 23a) (Type, Print)	Hugust 29 2012 Ltimore Manyand 21287					
	Stat	•	31. Date filed (Month, Day, Year)  32. Registrar's Signa	1) ORLEON'S STREET BUT ature barles	TIMORE MARY AND HILL					
	Registra	ľ	HULL OU COIL Charles B. A.	Tares						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic /Med Exami **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician / /Medical Examiner

Division of Vital Records, P.O. Box 68760, Car

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1- State of Maryland / Department of State of Maryland / Department / Depa										
ian	Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year  A Month									
cal	4a. Facility Name (If not institution, give street and number)  4b. City. Tow	n, or Location of Death  4c. County of Death									
ner	Johns Hopkins Bayview Medical Center Baltimo	ore									
	5. Social Security Number 6. Sex 1 Months D 6. Sex 1 Months D 6. Sex 1 Months D	ear If Under 24 Hrs. 8. Date of Birth Avs Hours Min. (Month, Day, Year) Aug, 17, 1946 Minnesota									
1	Usual Residence of Decedent  10a. State										
ctor	Maryland Howard Marriottsville	1 ☐ Yes 2 ☑ No									
Funeral Director	10e. Street and Number	de 10g. Citizen of What Country?									
era	1305 Crows Foot Road 21	USA USA									
by	3 Widowed 4 Divorced If Yes, Give 1 Yes 2 Year or Dates:	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White									
Completed	15. Decedent's Education 16a. Decedent's Usual O (Specify only highest grade completed) (Give kind of work of	ccupation 16b. Kind of Business/Industry									
Jg II	Elementary/Secondary (0-12) College (1-4 or 5+) Office Cler	tired)									
Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)									
10 B		Vernetta Ruth Ream									
ľ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (S	b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
		Foot Road; Marriottsville, MD 21104									
	1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Cond Shepherd (	4 Donation 5 Other (Specify) Good Shepherd Cemetery 8-30-2012E11icott City, Maryland									
	21. Signature of Fuperal Service Licensee  22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228										
	23a - art 1. Enter the disease, and in plication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition resulting in death)	Onset and Death									
	l/a atiloto come a consequence oi):	Sociated pneumonia									
lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)										
Examine	Cause (Disease or injury that initiated events c										
Medical E		resulting in death) Last  Due to (or as a consequence of):  d									
-	E I IL LEMAI L.										
ysiciar	23b. Was decedent pregnant in the past 12 months?  1										
by Pi		se given in Part I. 23e. Did tobacco use contribute to the cause of death?									
		1   Yes 2   No 3   Probably 4   Unknown									
Completed		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No									
Be C		26. Place of Death (Check only one)									
2	Pospital. 12 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify)										
ation:	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 2 Accident Pending (Month, Day Year)  28b. Time of Injury M	Injury at Work?  1  Yes 2 No									
Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, of building, etc. (Specify)	ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Medical (		he time, date and place, and due to the cause(s) and manner as stated.  my opinion, death occurred at the time, date and place, and due to the cause(s)									
Me		cense number 29d. Date signed (Month, Day, Year)									
	Jung D	74308 Angust 25 2012									
<	38. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4940 Eastern Avenue, Baltimore, MD, 21224									
ate trar											

DHMH 17 Rev 1/2001

Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 28 28 Physician/ AUGUST ennie 02:20AM 2012 Medical 4a. Facility Name (if not institution, give street and numbe Examiner 4b. City, Town, or Location of Death 4c. County of Death wantlad of batiques ian eramitle, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Manth, Day, Year) 9. Birthplace (State or Foreign 218-42-616 Hours Min. Director 1 □ M 2 🖫 F 1946 0 6 permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mentel Hyglene. Importent: If item 27 is marked other then "netural", or items 23e or 28a-f show any injury or other treumetic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 229 18 75 ISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done-during most of working life DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) terra Be Jord me/Relationship (Type, Prior) (Husband) timore MID Koad 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundial Service License 2122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 212932 disease or condition Nesk Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after deeth.

To the Funerei Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Embolism 1 🗌 Yes\_ 1 Yes 2 No 25. Was case referred to medical examiner? Certificate: To Be 26. Place of Death (Check only one) 2 **N**o Other: 1 🗌 Yes 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) WBBB 000 T2U PUA 38 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore, 2401 W. Belieder Alenna Come Duggal sina. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>2</u>012 Catherine M. Kaplan 10:30 A 24. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3 Kilkea Court Nottingham Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-20-4876 85 March 28, 1927 Baltimore, Maryland Director 1 □ M 2X F Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2XXNo Maryland Baltimore Nottingham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21236 United States 3 Kilkea Court death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Race - American Indian. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" 3 X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Margaret Schrenker Dominic DeFrank other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shament of Health a tant: If item 27 is 735 Walker Street Aberdeen. Maryland 21001 <u>Andrew Joseph Kaplan, Jr.</u> (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place.
Highview Memorial Gardens August 28, 1 X Burial 2 Cremation 3 Removal from State permit. Page Department c Important: If any injury or injury or Fallston, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Due to dr as a consequence of): Examiner oronar Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events and trar Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Box 68760 the attending | for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes 2XXNo To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Tes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3

Registrar

State

29b. Signature and title of certifie

AUG 3

0

Samvel 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

5505

29c. License number

D0047040

Hopkins Bayview Circle

29d. Date signed (Month, Day, Year)

27

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 8, per fh, g931 9-11-12sm
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of iv	iai yiai i		tificate of l		and Mental	Reg.	0.01	2 27826
ı	Physicia	an/	1. Decedent's Name (First, Mid	dle, Last)	<b>5</b>				2. Date of Month		Day Year	3. Time of Death
	Medic Examir		4a. Facility Name (if not institu	ion, give street and number)			4b. City, Town, o	r Location	08	-2	4c. County of Dear	
1	Â		820 N. WO	eshington S	4		Balt	imo			Baltin	LOYP
	Funeral Director		5. Social Security Number  213-32-5315  Usual Residence of Decedent	6. Sex	ge (In yrs. Ia 76		If Under 1 Year Months Days	Hours	Min. 8 Date of (Mont.)	of Birth n, Day, Yea 1 1 9 3	9. Bir	thplace (State or Foreign untry) N • C •
	land show	ţō	10a. State 10b. Cour	ity	10c. City	, Town or Loc	ation					10d. Inside City Limits
	e Mary r 28a-i notifie	Director	MD N/A		Bal	timor						1 X Yes 2 No
	s 23a o	Funeral	820 N. Washi	ngton St.			10f. Zip Code 21205	5		10g.	Citizen of What Co	ountry?
21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. Set of the Watural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	٥	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 📈 Widowed 4 ☐ Divorc	If Yes Cive			/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No		rigin? (Specify Yes or an, Puerto Rican, etc. y:	No- )	14. Race - Ame Black, Whit Specify: B	
15-	72 ho an "nat Medica	Completed	(Specify only hig	dent's Education ghest grade completed)		(Give k	ent's Usual Occup ind of work done of NOT use retired)		st of working	16b	. Kind of Business	Industry
212	l within ygiene. her tha t, the I		Elementary/Seconday (0-12	1 14/12	5+)		sewife				omestic	2
Maryland		0.	17. Father's Name (First, Middle James Boozer						her's Name <i>(First, Mid</i> zel Alex		•	
ary	2 should be fith and Menta Ith and Menta Ith is marked Itraumatic ev		19a. Informant's Name/Relation			19b. Mailin	g Address (Street a		ber or Rural Route Nu			o Code)
	1 and 2 s if Health item 27 other tra		Juana L. Lee 20a. Method of Disposition	-Daughter	Look Di			ingt	on St. E			
Baltimore,	Department of I Department of I Important: If it any injury or o			on 3 Removal from State r (Specify)	ce	metery, crem 19 Men		Pk.	Date 8/27/201	2 Ra		
Ba	permi Depar Impor any ir once.		21. Signature of Fund al Servic	∌Licensee <b>∼</b>					my March h Ave. E			MD 21202
	Prrysician/ Medical	- 22	23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that caused to only one cause on each line	d the death						9	Approximate Interval Between Onset and Death
	Examiner			Due to (o' as	a conseque	, '	essur	) i	0000			4 months
	d it d	Examiner	Sequentially list conditions, if any heading to it, modified cause. Enter Underlying	Due to for the	Nipsensa-e	-	11 1.5		i (h	0.0	N 0	
	fficate be executed g physician and as the burial-transit		Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):	1713nei	Me	13 due		مال	years
3760	ate be physicia the bur	<b>A</b> edical		d								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificathin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 🔲	Ectopic pregnanc Other (specify)	у			23d. Date of del Month	ivery Day Year
ds, P.O.	quires that t en signed b ould be deta	by	Part II. Other significant condi		icult	2	derlying cause giv	en in Pari		id tobacco		the cause of death?
Division of Vital Records,	sician: The law re certificate has be rector, page 2 sh	Completed	<u>'</u>						a	Vas an utopsy erformed? ⁄es 2.	prior to death?	opsy findings available completion of cause of 2 \square
/ital	rsician s certifi lirector	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ont 2 🗆 🗆	R/Outpatient	Otho	er:	ath (Check only one)	· · ·	a 🗆 au	
on of	I or Attending Physician: The la after death. Director: After this certificate ha I in by the funeral director, page	Certificate: T	27. Manner of Death  1 Natural 5 Pend 2 Accident Inves	28a. Date of inju	ry 2	28b. Time of injury	28c. Injury work	at			ury occurred	<i>TV)</i> .
Divisi	tal or Atters after de al Directo ed in by the		3 Suicide 6 Coul 4 Homicide deter	d not be rmined 28e. Place of Inju- building, etc		ne, farm, stree	et, factory, office			on (Street a Town, Sta	and Number or Rur te)	al Route Numb <b>e</b> r,
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check 2 L Medical	ng Physician: To the best of I Examiner: On the basis of e ng Nurse Practioner: To the	xamination a	and/or investig	gation, in my opinio	n, death o	occurred at the time, da	ite and pla	ce, and due to the o	ause(s) and manner stated.
	viti Po 1		29b. Signature and title of certif	of Perke	tho	Cla	29c. License		7790	29d. [	Date signed (Month	, Day, Year)
			30 Name and address of person	rfetto CRN	1P	4940	Easter	nA	re. Bal	tino	re Mid	21224
	Stat Registra		31. Date filed (Month, Day, Year) AUG 3 0 2012	Server 32. Registra	ar's-Signatur	re Maj						,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 Donald Long 4:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care, Inc. Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Feb 18, Year) 29 Mary land Director 220-20-2299 83 1 XM 2 - F filed within 72 hours over... ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, It e Medical Examinat must be multified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖳 Yes 2 🗌 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 W. Franklin St. 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Unic (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unit (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed Department of Heelth end Mental Hy Important: If Item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $400 \;\; Fords \;\; Lane; \;\; Reisterstown, \;\; MD \;\; 21136$ Eugene Willig - nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Ronal Wade, Director 655 W. Baltimore St; Baltimore, MD 21201 22 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Preimo thorax disease or condition welled Medical resulting in death) Due to (or as a consequence of): Examiner Chromie obstructive civo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Duvi to for as a consecuence of: attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been sign-page 2 should be 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 🗌 Yes 2 **₩**No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 other (Specify) 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA ÷. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: 10 the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year, MD D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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31. Date filed (Month, Day, Year)

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82. Registrar's Signature

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Baltimero,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26,2012 MARCIA B. LYONS AUGUST 3:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3434 LIBERTY PARKWAY BALTO DUNDALK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 214-38-3186 72 Director 1 🗆 M 2 🛣 F MARCH 19,1940 MARYLAND 28e-f shov r than "natural", or items 23a or 28e-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD. BALTO. DUNDALK 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3434 LIBERTY PARKWAY 21222 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates. 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) LAB RESEARCHER JOHNS HOPKINS other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Importent: If item 27 is markeny injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BERTHA C. STUGINSKY LEONARD B. SWISS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 1820 QUEEN ANNE SQUARE BEL AIR, MD. 21015 JENNIFER LYONS MYERS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER 8-31-2012 BALTO. MD. of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD., 21236 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a in the past 12 months? Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of pers

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

paretta Mercer		For State legistrar	or Maryland / Dep C	ertificate d		iu ivierita	ai riygi		j. No.	201	2 2782
Physician Medical Examine	1	<ol> <li>Decedent's Name (First, Middle, Last</li> </ol>	Evonna		Merc	er		ate of Death Nonth Ugust 25,		Year	3. Time of Death 1702 hrs
Healtar Examine		Baretta 4a. Facility Name (if not institution, give			4b. City, Town, o			ugust 25,		ounty of Death	
	4	4769 Melbourne Road  5. Social Security Number 6. S	I 7 And the rise	s, last birthday)	Baltimore  If Under 1 Ye	ar If Under:	24110 10	Data of Birth	(1414/000	ANNOVA O Birt	hplace (State or
Funeral Director		5. Social Security Number  6. Security Number  214-68-4311	4 13		Foreign						
any	_ ⊢	10a. State 10b. County	10c. Ci	ity, Town or Loca							10d. Inside City Limits
Aaryland 28a-f show 1 at once.	5	MD NA		Baltin				т	A		1 Yes 2 No
h the Maryland 3a or 28a-f sh		10e Street and Number 4769 Melbourne				229			Ü	n of What Coun J . S . A .	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No	lf i	as Decedent of H Yes, specify Cuba	an, Mexican, F					can Indian, Black,
urs afte	⋧┞	15. Decedent's Education (Specify on	or Dates:	16a. Decede	nt's Usual Occup	ation (Give kir		done		d of Business/Ir	
036 tthin 72 ho ne. r than "na fedical Ex	Сошріння	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)	1 -	nost of working lif ntertai	.ner				f-Emp	loyed
21215-0036 Juld be filed within 7 Mental Hygiene. Tevent, the Medica		17. Father's Name (First, Middle, Last)					Name (Firs	st, Middle, Ma La a	aiden Su	ırname)	
2121: Ould be fill Mental H marked ic event,		Ernest Gales 19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Stre				er, City	or Town, State,	Zip Code) 21229
MD ad 2 sho alth and 27 is sumat		Robert Donalds			Melbou sition (Name of c		Da			cation - City or	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Department. If item 27 is injury or other traumati		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	crematory or o	ther place)	9	0/1/2	2012	Woo	odlawn	, Md
Balt permit. Depart Import injury	1	21. Signorule of Funeral Service Licens	ee a NA+	<sup>22</sup> . M 4	Name and Address	of Facility H Wes Dash A	ite,	Balt:	imoı	re, Md	21215
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Examiner		mmediate Cause (Final disease a.	lypertensive Atheros		liovascular D	is <b>ea</b> se					Death
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lox 68760, eath certificate be executed attending physician and for use as the burial - transit	<u> </u>	UNPENDED d.	AMENDED								
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Box 687 (seath certification attending placed for use as the		past 12 months?	1 Live birth 4 Pregnant at time of	do oth	etal death 3 other (Specify)	Ectobic b	oregnancy		I IVI	onth D	ay Year
BO, he deat y the at hed for	Puysician	1 Yes 2 No 9 V Unknown  Part II. Other significant conditions	9 Unknown	at resulting in the	underlying cause	civen in Part		23e Did tob	acco use	e contribute to t	he cause of death?
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Division of Vital Records, P.O. pital or Attending Physician: The law requires that the Jurs after death.  eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined	28e Place of Injury - At	t home, farm, stre	eet, factory, office	building, etc.		Location (Store Town, Sta		Number or Rui	al Route Number, City
	adical	one) 2 Medical Examiner:	in: To the best of my knowl On the basis of examination and manner stated.								
	Ě	29b. Signature and title of certifier				se number				te signed (Mor st 29, 2012	th, Day, Year)
	-	30. Name and address of person who c		em 23a)					aguc	, 2012	
		Ling Li, MD Assistant Me	edical Examiner 90	0 W. Baltimo	ore Street, Ba	ıltimore, M	D 21223	3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Month Physician/ Medical 4c. County of Death Facility Name (if not institution, give street and number, **Examiner** FREderic are+Rehabilitation Frede 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min Year) **Director** 434-38-7370 1 🔀 M 2 🗆 F 82 April 10, 1930 Lousiana 28a-f show 10d. Inside City Limits 10a. State 10c, City, Town or Location must be notified at Director MD 1 Yes 2 X No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Rosemont Ave. 23a 21701 USA items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Black 1 Yes 2 X No Specify: If Yes Give 3 ☐ Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) landscaping gardner 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Bell Savant Robert Hunter Mills other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 25 Sheridan Ln; Brunswick, MD 21758 Angela Mills Ball - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Poard Ronal d 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final moumonitis Physician/ Assiration disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as the IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death signed by the a 9 Unknown Unknown Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D43091 8-24-12

State Registrar

Zarid 1 80 31. Date filed (Month, Day, Year) Registrar's Signature

Jacos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

**AUG 30** 

TUC

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 27831 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ward Merlin Meier August 2012 5:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 715 Maiden Choice Lane PV314 Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 478-16-1250 90 **Director** 1 🖾 M 2 🗆 F Jan. 9, 1922 Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 21228 USA 715 Maiden Choice Lane PV314 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deces? Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural" Completed 3 X Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Electrical Engineer Westinghouse Ith and Mental Hygier

27 is marked other t

traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest Meier Hazel Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13112 Briarcliff Terrace Apt 508
Germantown, MD 20874 27 Greg Meier Son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State <u>-</u>: ხ Important: I any injury or once. Crestlawn Mem. Garden 8 29-2012 |Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke Tuneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affect, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset in Death disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 🗌 No 1 Yes 2 L 9 Unknown g Unknown ing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မှ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred I or Attending F after death. 5 Pending 2 No Accident Investigation 1 Yes Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioners. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e signed (Month, Day, Year)

State Registrar

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Division of Vital Records,	or Atter frer de ilrecto	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc.		arm, street, fact	ory, office		28	f. Location (S City or Tow			ural Route Numbe	er,
۵	Hospital or Atten 24 hours after deat Funeral Director: etely filled in by the	cal	29a. Certifier 1 Certifying Phy	sician: To the best of m	v knowledne	death occurred	1 at the time	data and nis	ace and	dua to the co	uscola) a	nd manner on a	stated	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Othin Et hours after death.  Othin Et murail Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical (	I (Check 2 ⊔ Medical Exam	iner: On the basis of exa se Practitioner: To the l	ımination and/	or investigation.	in my opinio	n, death occu	irred at th	e time date a	nd nlace	and due to the	cause(s) and man	ner stated.
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	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar			MD	Office		MITHIC	IX. T	10 0	OLU T	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27833 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 20ĬŽ 5:05 PM DAVID COFFMAN MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | No. (Month, Day, Year) | 957 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Funeral 1 🕅 M 2 🗆 F Kentucky 407-80-9946 54 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 X Yes 2 No Louisville Jefferson Kentucky 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 40222 1605 Helmridge Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1979 1 □ X Yes 2 □ No 1984 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify.White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Post Office Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Joann Hinkebien John May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1605 Helmridge Ct., Louisville, KY 40222 Erin May (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Buria 2 Cremation 3 Removal from State 8/29/2012 Radcliffe, KY Kentucky Veterans 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 ature of Funeral Service Lix nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a con quence of): 20-1-20 disease or condition Medical Examiner resulting in death) if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 25 After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ 4 hours after death. • uneral Director: After this ed filled in by the funeral di 28c. Injury at 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury 5 Pending Watural 1 Tes ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined , h.
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completed filler Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2012

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Şignature

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELECTRON KEBEBEW

31. Date filed (Month, Day, Year)

AUG 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST Year Physician/ Day JR E DWIAR D J MATULAITIS 201 12:20PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTZ GLEN BALTIMORE WASHINGTON BURNIE ARUNDE MEDICA If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday **Funeral** Hou*r*s 1 🔀 M 2 🗆 F Days Yrs **Director** 218-58-9960 60 19, February Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Manyland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2x No Maryland Anne Arundel Pasadena ms 23a or must be n ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Ullman Road United States items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ö 2 1 Never Married 2 x Married Maryland 21215-0036 Yes 2 x No If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour popartment of health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Joseph Matulaitis, Sr. Mary Goetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Matulaiatis/Wife Ullman Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 28, cemetery, crematory or other place)
West Arundel
Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Lice MD1386 I lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part | Ente | Le disease, or co shock, or head | Line e. List only Interval Betweer Immediate Cause (Final Onset and Death Physician/ VENTRICUL AR ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MYOCARD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last HYPERTEN SI eau attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown cate has been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No this certificate Yes Division of Vital 25. Was case referred to medica funeral director. 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify, Hospital: မ 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural iniury 5 Pending work?
1 \sum Yes 2 \sum No Accident Investigation 24 hours after death Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Sign 29c. License number 29d, Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 206 GLEN BIRNIE SANG C Doft 1600 CRAIN di. i) HIGHWAY.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ar 7/2 63 SINO 3 US 0/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lecation of Death 4c. County of D∉ath **Examiner** 8 Ba mon ers 78 00 93000 1 Social Security Numbe If Under 24 Hrs. 7. Age (In yrs, last birthday If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Croatia 1**X**□ M 2 □ F Months Days Min 12/12 215-13-0814 Hours 59 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director Examiner must be notified 1 🗆 Yes 2 🔀 No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 20878 878 Bayridge Drive Croatia items ; permit, Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
White Ś 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **5 +** Elementary/Seconday (0-12) Scientist American Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gordana Markovic Branko Markovic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11825 Smoketree Road Potomac MD 20854 Melanija Tomic Auth Agent 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic y`or other place) Crem 1 Burial 2 X Cremation 3 Removal from State 8/28/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signate of July ral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or illijery Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by 1 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1/ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၀ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work? 1 \( \text{Yes} \) 2 \( \text{No} \) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pending 24 hours a er decth. Funeral Director A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide determined filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4Check 29c. License number 29d. Date signed (Month. Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRE HE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) AUG 3 0 2012

32. Registrar's signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:25p M Jane Nadler August 2012 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Patuxent River Health & Rehab Center Prince George's Laurol . Social Security Number 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Hours 1 M 2 X F Months Days Min (Month, Pay, Year) 02/13/1928 122-20-6314 84 **Director** Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Bowie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 14004 Heatherstone Drive 20720 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify 3 ¥ Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Jack Goldman permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic v Julia Svennson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14004 Heatherstone Drive, Bowie, Maryland 20720 Paul Nadler - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns: 08/28/2012 Olney, Maryland 21. Signature of Fundal Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ CARDIOVASC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MENTIA. ABVANCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ò Day Month Year Pregnant at time of death detached P.O. þ signed I Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: A 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UZO UNFGIBU, MD 7350 VAN BASAN RD SUITE 220 LAUREL, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20°1 2 10:25 Harold Julian O'Lynnger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign May 17, Hours Min Days Director 1927 Michigan 371-24-3181 1 😡 M 2 🗆 F show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 28a-f 1 Yes 2 v No MD Annapolis Anne Arundel 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21403 IISA 1206 Holly Day Court death 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. or Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes. Give 2 No 1945filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Completed Specify 3 - Widowed 4 - Divorced Year or Dates 1947 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 underwriter insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William B. O'Lynnger Ruby K. Morey and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 Holly Day Court; Annapolis, MD 21403 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patrick O'Lynnger - son 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 Durial 2 Cremation 3 Removal from State 5 Other (Specify) Donation 3 Si nature for my Sarvice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between i, sici an Onset and Death disease or condition resulting in death) Jyn Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause It immediate the cause it is a sequential to the cause it is a sequen Examine Due to (or as a consequence of) Cause (Disease or in that initiated events and-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ò in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No the 9 Unknown Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performe page ; certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date, signed (Month Day, Year) 8 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 00 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lee John Pettit, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 916 Kent Baltimore Avenue Catonsville Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Hours 215-70-2257 Director 1 🕅 M 2 🗆 F 57 Dec. 19,1954 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? pe Funeral ms 23a 916 21228 Kent Avenue United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Architect Architecture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever မ Gene Pettit Virginia Irvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Kathleen Pettit / Wife 916 Kent Avenue, Catonsville, Maryland 21228 ant: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Crestlawn Mem'1 Gdns 08/31/2012 | Marriottsville, MD Donation 5 Other (Specify) Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility MacNabb Funeral Home, P.A. Taylor 301 Frederick Road, Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocarl. disease or condition Due to (or as a consequence of): Medical resulting in death) **Examiner** Atheno chard-Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of ng physician and as the burial-transit incontector that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No After this certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Accident Investigation completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 22085 28 2062

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Registrar

DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year)

Server S. pares

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 1523 PM ARON. P Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE LMMC If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Min 212-44-7636 67 **Director** 1 DXM 2 D F Maryland Oct 17, Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b County must be notified at Director 1 X Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21201 23a permit. Page 1 and 2 should be filed within 72 hours after death with 126 W. 27th St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. o þ 1 Never Married 2 Married Specify: Black 1 Yes 2 X No Specify: 27 is marked other than "natural", raumatic event, the Medical Exar 3 🗌 Widowed 4 🙀 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) home improvement handyman 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental ည Eva Robinson Aaron Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4124 Fairfax Rd; Baltimore, MD 21216 and is m 19a. Informant's Name/Relationship (Type, Print) Michael Powell - brother of Health a item 27 i other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state 22. Name and Address of Facility State Anatomy Foard Signature of Funeral Service Licenses Ronal d S Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bouel Due to (or as a conseq Physician/ disease or condition resulting in death) Medical as a consequence of): **Examiner** CENTIFICATION REPROVED BY WENCER EXAMINES Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events and use as the burial-tran Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L Yes 2 No Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Onknown Certificate: To Be Completed should 24b. Were autopsy findings available prior to completion of cause of DESSEMENATED ENCEPHALD-24a. Was an autopsy page 2 performed? death? MYFLITIS 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examine? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 Yes 28d. Describe how injury occurred injury ☐ Natural ☑ Accident 5 $\square$ Pending 2 410 MEG TUBE HACEMENT Investigation 4:06 PM

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.
Funeral Director: After this etely filled in by the funeral di within 24 ho
To the Fune
completely 1

Baltimore, Maryland 21215-0036

2 Maccident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office 28f. Loca	tion (Street and Nu	umber or Rural Route Number,
(Check 2 Medical Examiner	an: To the best of my knowledge, death occurr : On the basis of examination and/or investigation Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, occurred at the time, date and place, and c	date and place, and ue to the cause(s) a	d due to the cause(s) and manner stated and manner as stated.
29b. Signature and title of certifier		29c. License number	29d. Date si	igned (Month, Day, Year)

GREENE ST.

> 29d. Date signed (Month, Day, Year) 29c. License numbe RESOU1

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers

BOUTSIKARIS DANTEL 31. Date filed (Month

State

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Laura Mackay Phillips 25,2012 Medical AUGUST 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Batrimore If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Country) 12-22-1919 MD Director **214-16-3073** 1 □ M 2 💢 F or then "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD ıı⁄a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 Whitmore Avenue 21216 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐X\o If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: African-American 3 ₩idowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 the end Mentel Hygiene.
7 is marked other then " Elementary/Secondary (0-12) College (1-4 or 5+) Afro permit. Page 1 and 2 should be filed wit. Department of Health and Mentel Hygier importent: if item 27 is marked other ti eny injury or other treumetic event, the once. 12th Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otho Mackav Mabel Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aura P. Byrd/Daughter 1906 Madison Avenue, Baltimore, MD 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veterans 9-5-2012 Owings Mills, MD 21. Signature of Furieral Service 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 For 1. Enter the disease, or corun cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Liver lailure disease or condition resulting in death) due to Acetaminophen Toxicity days Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of FROM APPROVED BY MEDICAL EXAMINE Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ate hes been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabetes mellitus 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 A No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examine 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending n 24 hours after death.

In Funerel Director: After the fulled in by the fulled in the fulled Consumption of Acetaminophen
28f. Location (Street and Number or Rural Route Number, 8/13/12 14:00 M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Gity or Town, State)

GOY Whitmore Ave, Batrinse, MD 21216 Home Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hour To the Fune completely fi 29d. Date signed (Month. Day, Year) use of death (Item 23a) (Type, Print) Sinci Hospital of Bahmare, 2401 W. Belveder Marshall Moreus MD. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-201

State

Registrar

AUG 30

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jacqueline S. Pavy August 29, 201<sup>Y</sup>2<sup>ai</sup> 6:45 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 215 Belmont Forest Court, #402 Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours Min **Director** 220-54-5387 64 1 - M 2 XX May 20, 1948 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 215 Belmont Forest Court, #402 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian ۾ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ye 1 and 2 should be filed within 72 t of Health and Mental Hygiene.

If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Katherine Jack Sipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Miller / Daughter 508 Limerick Cir. #304 Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2012 4 Donation 5 Other (Specify) Enterment Dulaney Valley Timonium, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Wterine Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 124 hours after death. 124 hours after death. 8 Funeral Director, After this certificate has been signed by the a pietely filled in by the funeral director, page 2 should be detached i 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, iabetos 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes Yes 2 N **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DNo ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 10gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) or M.D. 1734 AUG 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death POLAND Physician/ BETTY August 27, 2012 11:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 224 Old Line Avenue Laure1 Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min (Month, Day, Year) **Director** 216-40-8968 1 M 2 X F 69 03/31/1943 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location Director MD 1 Yes 2X No Anne Arundel Laurel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 224 Old Line Avenue 20724 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Armed Forces?

1 Yes 2 No 14. Race - American Indian or Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. "natural" Specify: White 3 - Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) 10 Bartender Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Gibson Lucille Sneed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Wines / daughter 8234 Elvaton Road, Millersville, MD 21108 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State 4 Donation 5 Other (Specify) West Arundel Crem. 08/30/2012 | Odenton, MD 21. Signature of F peral Service Ligens 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final TYMUTIVE Onset and Death Physician/ CHRONIC Medical resulting in death) Due to (or as a consequence of): Examiner yeary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Day Pregnant at time of death Year signed by the a ld be detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director After this certificate has be completely filled in by the funeral director, page 2 s. 24a. Was an autopsy Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes ပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUGUST 24, 2012 Deborah PROFILI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2014 COLGATE CIRCLE FOREST HILL HARFORD Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 215-58-3898 Director 1 □ M 2 🛣 Yrs MARYLAND 61 1-15-1951 or items 23a or 28a-f show niner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD. HARFORD FOREST HILL 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2014 COLGATE CIRCLE 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. WHITE 5 by 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No traumatic event, the Medical Exa If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) REGISTER NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ္ HARRY BUEHLER CLAIRE SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i **SPOUSE** JOHN PROFILI 2014 COLGATE CIRCLE FOREST HILL, MD. 21050 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Page 1 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD. ATLANTIC CREMATORY 8-27-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL ATR 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STALL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): use as the burlal-transi Due to (or as a consequence of): resulting in death) Last Box 68760 € attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day To the Hospital or Attending Physician: The law requires that the deal within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the all completely filled in by the funeral director, page 2 should be detached formulated in the funeral director, page 2 should be detached formulated. 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mone 2 1 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNO မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 30. Name and address of person who c death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Regist Registrar DHMH 17 Rev 06-2011

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hedwig T. Patchak 3:40 P M 2012 August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Sunrise Assisted Living Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months 176-16-9337 **Director** 91 1 □ M 2XX Hazelton, PA December 03,1920 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location must be notified at 10d, Inside City Limits Director Ellicott City Maryland Howard 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 items 23a United States 2633 Legends Way 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2XXNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 ₩ Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Armco Steel 12 Data Entry Department of Health and Mental h Important: If item 27 is marked oth any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Budzinski Anthony Mikolaiczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2633 Legends Way Ellicott City, Maryland 21042 Richard H. Patchak (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State September 05, 2012 Rosedale, Maryland Cardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Alzheimer's Disease disease or condition resulting in death) years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Debility 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ (Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an performed? 2 🗆 No Yes 2 X No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 XXOther (Specify) Assisted Living 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Records, P.O. Box 68760 Division of Vital

> MD. D56531 August 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 8600 Snowden River Pkwy # 301, Columbia, Maryland 21045

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29a. Certifier

(Check

only one

29b. Signature and title of certifier

32, Registrar's Signature

12-06292

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aul Stuart Pfei		State of Maryland 1- For State Registrar		nent of cate of		Mental Hy	_	2 0 g. No.	12 2784				
Physici Medical Exami		Decedent's Name (First, Middle, Last)     Paul Stu	art Pfeiffe	r			2. Date of Death Month August 21,	Day Year	3. Time of Death 0230 hrs				
		4a. Facility Name (if not institution, give street and number Baltimore Washington Medical Center	)	4	b. City, Town, or Lo Glen Burnie	cation of Death	,	4c. County of D					
Funeral Director		212-96-0068 1×M 2 F	ge (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	- 1e						
nd how any cc.	Ŀ	Usual Residence of Decedent  10a. State 10b. County  MD Baltimore	10c. City, Tow	n or Locatio	on	Essex			10d. Inside City Limits 1  Yes 2 No				
with the Maryland ms 23a nr 28a-f show be notified at once.	Director	10e. Street and Number 112 South Taylor Avenue			10f. Zip Code	21221	10	g. Citizen of What	Country? USA				
r death nr ite	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	? X No	1f Ye	Decedent of Hispar is, specify Cuban, M Yes 2 No s	lexican, Puerto	Rican, etc.)	White, e	White				
17215-0036 Id be filed within 72 hours afte fental Hygiene. 1arked other than "natural", event, the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or 12			s Usual Occupation st of working life. DO Handy	O NOT use retir /man	ed)	16b. Kind of Busin	Service				
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	17. Father's Name (First, Middle, Last) Howard Pfeif	aiden Surname) ary Dignan										
e, MD 2121  I and 2 should be f  Health and Mental  item 27 is markee	٩	19a. Informant's Name/Relationship (Type, Print) Lyle F. Hodge / Aunt		2008 I	Address (Street ar Buoy Drive, S	Stafford, V	Α						
Baltimore, MD 2 permit Pages 1 and 2 shou Department of Health and Important: If iten 27 is r injury or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from St  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	ate crema	atory or other esapeak	e Crematory  ame and Address of	8/3	Date 30/2012		tsville, MD				
Physician		Dorota Marshall  23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do r	* 1					re, MD 21203  Approximate Interval Between Onset and				
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Diffuse A. Due to (or as a constitution)		eumon	ia with c	omplica	tions		Death				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C.	equence of):										
cuted md transit	I Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.											
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  1 Yes 2 No 9 Unknown  23d. Date of delivery Month Day											
s, P.O. nires that the n signed by t	Ą	Part II. Other significant conditions contributing to deat	h but not resulti	ng in the un	derlying cause give	n in Part I.	1 Yes	2 No 3	e to the cause of death?  Probably 4  Unknown				
tal Records tian: The law req certificate has beer	Completed	25. Was case referred to medical			0001		24a. Was ar autops perform 1 Yes 2	y prior ned? deat	e autopsy findings available to completion of cause of h?  Yes 2 No				
Vital hysician this certi	e Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatie	ent 2 🗸 ER/0	Outpatient		Death (Check oner 4 Nursing	nlyone) Home 5 R	esidence 6 C	ther:				
ion of tending Pheath.	ation:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	iry 28b. rear)	. Time of Inj		t Work?	28d. Describe ho	ow injury occurred					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification	3 Suicide 6 Could not be determined (Specify)	ijury - At home,	farm, street	, factory, office build	ling, etc.	28f. Location (Sta or Town, Sta		r Rural Route Number, City				
To the Howithin 24 h To the Funcompletely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.											
	Ĭ	29b. Signature and title of certifier			29c. License nu O.C.M.E			29d. Date signed August 21, 20					
8		30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine			Street, Baltim	ore, MD 212	223						
St Regist	ate	31. Date file (Month Dev Year) 32. Registra	r Signature	nes.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh e931 9-14-12 vt State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Vernell August 9:24 Pearson 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Months 1 □ M 2**½**□ F 62 Yrs. 07/09/1950 N.Carolina 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2√ No Specify: Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Years Sales Representative Comcast 18. Mother's Name (First, Middle, Maiden Surname) Α. Armstrong Jerusha Herring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1113 Elbank Ave., Baltimore, MD 21239 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) -30-12 OnSite Cremation : Baltimore, MD Forephotes Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 Interval Between Onset and Death Hepatoce lular month Due to (or as a consequence of): Auto immune 20 year Due to (or as a consequence of): Due to (or as a consequence of):

Physician/ Kenzie Medical 4a. Facility Name (if not institution, give street and number) Examiner 1710 Lakeside Avenue Social Security Number **Funeral** Director 54-4164 Usual Residence of Deceder or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at hours after death with the Maryland 10a. State Director MD 10e. Street and Number Funeral 1710 Lakeside Avenue 11. Marital Status 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 XDivorced Il Hygiene. Elementary/Secondary (0-12) Be filed 17. Father's Name (First, Middle, Last) should be file h and Mental F 7 is marked of of Health and Mental For Health and Mental For Health and Mental For Health arked of them 27 is marked or other traumatic eve ည James 19a. Informant's Name/Relationship (Type, Print) Irma Robinson (sister) 20a. Method of Disposition Page 1 0 = 0 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licersee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -- Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin signed by the attending physician and id be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident s after death Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completely filled hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) (PHYSICIAN) 29 D44670 08 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 601 N. CAMOUNE ST #71506 BALTIMONE M) 21287 STEPHEN D. SIGGON

√DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2012

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Eva M. Rusk		S 1- For State Registrar	tate of Maryla		ertificate			Mental Hy		Reg. No	. 20		2 2	784
Physicia Medical Examin	n/	1. Decedent's Name (First, Midd Eva M. Rusk	ile,Last)						2. Date of De Month August 2	Day	Year		3. Time of 1	
~ \		4a. Facility Name (if not institution	on, give street and nu	ımber)		4b. C	City, Town, or Lo	cation of Death	August 2	4	c. County of D	)eath		_
. •		Calvert Memorial Hos	<u> </u>		rince Frederi				Calvert					
Funeral Director		5. Social Security Number 220-34-7918	6. Sex	7. Age (In yrs	. last birthday) 76 y	_	Under 1 Year Ionths Days	If Under 24Hrs. Hours Min.	11/04	•	35 (************************************	oreign Cour	Washi	ngton
any	F	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	ation						<u> </u>	10d. Inside	City Limits
	إج	Maryland Anne	Arunde1	L	othian								1 Yes	2 X No
Maryla 28a-f	힣	10e. Street and Number				10	f. Zip Code			10g. Ci	tizen of What	Count	у?	
ith the 23s or	흶	207 B Street	12 Was Day	cedent Ever in	118 113 14	Jas De	20711 ceedent of Hispan	nic Origin? / Sn	acify Vac or N	USA	14. Race - A	meric	an Indian	Black
r death with the Maryland or items 23a or 28a-f sho must he notified at once	Funeral Director		Married Armed F				pecify Cuban, M			0-	White, e		an malan, i	Sidon,
after d	교		vorced If Yes, Give Yes or Dates:	ar 11	1		2X No s				Specify: Wh			
2 hours	를 달	15. Decedent's Education (Spe Elementary/Secondary (0-12)					sual Occupation f working life. Do				Kind of Busin		dustry	
036 ithin 7: ne.	Completed	12			Laund	ry				Νι	ursing	Hor	ne	
		17. Father's Name (First, Middle Peter Louis Mag						Mother's Name ena Fra			,			
212 ould be Menta marke	_,	19a. Informant's Name/Relation					dress (Street ar	nd Number or R	ural Route Nu	ımber, (	City or Town, S		Zip Code)	
MD and 2 shoulth and 2 shoulth and 2 shoulth and and 27 is a sum at is		Valerie Cowan/	Daughter	Loo			. Stree		m,Mary Date		Location - Cit		Ctata	
Ore, ges l ar of Her ther tr		20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Removal fr	om State	crematory or o	other p					altimor	•	·	
Baltimore, permit. Pages 1 as Department of He important: If ite	ŀ	4 Donation 5 Other S 21 Signature of Funeral Service	pecify: Licensee Steph				ory, Inc							
Dem Perm	-	1) Lept W.	5		29	9 F	rederic	k Road	Baltim	ore	,Maryla			
Physician Medical Examiner		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line.	nsive_	Atheros								Between	Onset and eath
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8760, tificate be ng physici		IF FEMALE: 23b. Was decedent pregnant in t		outcome of pre		etal de	eath 3	Ectopic pregnar	псу	23	3d. Date of del	livery Da	———— iy	Year
D.O. Box 6876 that the death certificate by the attending phy detached for use as the letter of the strength o	Physician/M	past 12 months?  1  Yes 2 ✓ No 9 Ur	, L	nant at time of o	death 5 (	Other	(Specify)							
P.O. Es that the ces that the ces that the ces detached by the ces detached	뒨	Part II. Other significant condi	tions contributing to	o death but not	resulting in the	under	lying cause give	en in Part I.			use contribut			
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Division of Vital Records, tal or Attending Physician: The law requirens after death. In Director: After this certificate has been silled in by the funeral director, page 2 should be	Completed	•					_		auto perf	psy orm <u>ed</u> ?		r to co	mpletion of	
tal Recting: The certificate ector, page	ဦ	25. Was case referred to medical	a) [				26 Place of	Death (Check of	1 Yes	21	No 1 🗸	Yes	2	No
Vita hysician this cer	면 일	examiner? 1 ✓ Yes 2 No	(Hospital:	Inpatient 2	✓ ER/Outpatie	nt 3[				Resid	ence 6 C	Other:		
ding Ph.	<u>"</u>	27. Manner of Death		of Injury ı, Day,Year)	28b. Time o	f Injury		t Work?	28d. Describe	how in	jury occurred			
Sior Attend or death rector: by the	<u>ič</u> ati	2 Accident Inve	nding estigation	e of Injury - At	home, farm, str	eet, fa	ctory, office build		28f. Location	(Street	and Number o	or Rura	al Route No	umber, City
Divis ospital or / hours after meral Dire	Certification:		uld not be ermined (Specify)		,,				or Town,					
		( one on one	Physician: To the bes											
Tot with Tot com	Medical	29b. Signature and title of certific	and manner s				29c. License n				Date signed			ar)
		aluce	ell.	1			O.C.M.	E.		Au	gust 25, 20	)12		
v/	Ì	30. Name and address of person	n who completed cause Assistant Medic		1.	Balt:	more Street	Raltimore	MD 21222					
)() Sta	ite	Zabiullah Ali, M.D.  31. Date filed (Month, Day, Year,		egistrar's Signa		Daill		Daitii i i i i i i						
Registi		AUG 3 0 2012		A	house									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUBENSTEIN August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death North WEST HOSPITAL Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 64 Director 215-50-8279 1 M 2 KF Maryland Nov 24, 1947 Usual Residence of Deceden or 28a-f shov within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, <u>the Medical Examiner must be notified at</u> 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21223 2235 W. Fayette St. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) restaurant waitress Be Page 1 and 2 should be filed in ment of Health and Mental Hyrant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irene Wayland Ruben Kolker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State Zip Code) 348 Foreland Garth; Abingdon, MD 21009 Lauren Brown - daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature of Funeral Service Lice ve 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Small CEll Lung disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and que to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

August, 21,2012

Court Road, Randalktown, HD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29 Pay 2012<sup>ear</sup> Blaine Richard Robinette 10:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Harford Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours Director 219-44-0510 **1**X M 2 □ F 66 Maryland Nov. 15, 1945 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No **Elkton** Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a within 72 hours after death with 145 East High Street 21921 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 

XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married a.m. 21215-0036 1 Yes 2 No Specify. and Mental Hygiene. is marked other than "natural", If Yes, Give Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other than my nijury or other traumatic events. 12 Truck Driver Concrete Company Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arch Elijah Robinette Iona Elizabeth Cadwalder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 145 East High St., Elkton, Maryland 21921 Mary K. Robinette / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place AUGUST 4 Donation 5 Other (Specify) <u>Garrison Forest VA Cem. 9-11-2012 Owings Mills, MD</u> 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ CEREBROVASCULAR ACCIDENT Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician by Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: ROBINETTE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Yes No 3 Probably 4 Unknown BLAINE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform Yes 2 X No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes 2 **X** No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of

30. Name and address of p TRACIE L.

31. Date filed (Month, Day, Year)

MORGAN,

2300 DULANEY VALLEY RD.

rson who completed cause of death (Item 23a) (Type, Print)

CRNP

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

TIMONIUM, MD 21093

20b. Place of Disposition (Name of

Physician. Medical Examiner

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

29b. Signature and title of

31. Date filed (Month, Day, Year)

AUG 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUANANIDA

JoAnn Gibbs /daughter

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director; A filled in by within 24 hou

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completely fi

	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State E. Harr	isburgcemete		12 Ha	arrisbu	rg PA
	21. Signatur of Inera Service Lenses	Egrolly h	22. Name and Address of Facil Connelly	ity 300 M Funera	ace Av	ve. Bal	to. MD sex 21221
ical Examiner	23a. Part 1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any least good in a disease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	enter the mode of dying, such as	s cardiac or respira	itory arrest,		Approximate Interval Between Opset and Death
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
ted by Pl	Part II. Other significant conditions conf	tributing to death but not resulting in the		t I. 23e	_		the cause of death?
Completed by		ry astry	disease		a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	Othor	ath <i>(Check only on</i>	- 1.	3 Other (See	(6)
Medical Certificate: 1	27. Manner of Death  Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time injur	e of 28c. Injury at	28d. Des	scribe how injur		
al Cert	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		ation (Street and or Town, State		al Route Number,
Medica	29a. Certifier 1 Certifying Physic (Check only one) 3 Certifying Nurse	ian: To the best of my knowledge, dea er: On the basis of examination and/or in Practitioner: To the best of my knowled	vestigation, in my opinion, death of	occurred at the time	date and place	and due to the o	ause(s) and manner state

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Congressional Court Baltimore MD

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

2

29c. License number

male

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 27, Virginia Norma Russo 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Emeritus at Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Jan 2, 1921 g. Birthplace (State or Foreign Mary land Director 214-16-9135 1 🗆 M 2 🗙 F 91 tal Hygiene. ad other than "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at filed within 72 hours efter death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 K No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6451 North Charles Street 21212 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. þ 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file if Health and Mental F item 27 Is marked of other traumatic ever ည Samue 1 Frank House Helen Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Conoscenti-daughter 20 Stillway Ct., Cockeysville, MD 21030 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Importent: If ite
eny Injury or ott 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley 8/30/12 Timonium, MD 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DULMONALE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examine Due to (or as a consequence of) igned by the attending physicien and be detached for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 W No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at After 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e and title of certifier 29d. Date signed (Month, Day, Year) HUGUST 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Tavoon 32. Registrar's

DHMH 17 Rev 06-2011

State Registrar

**Division of Vital** 

Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 26 Day 2012 Marie Reals 2:28 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 8. Date of Birth (Month, Day, Year) March 14,1927 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign Country) Director 520-22-1330 1 🗆 M 2 🖾 F 85 Indiana Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours efter death with the Merylend Depertment of Heelth and Mentel Hyglene. Importent: if item 27 is merked other then "neture!", or items 23e or 28e-f show will jujury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director New York Schenectady Niskayuna 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4213 Consaul Road 12304 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 ⚠ No If Yes, Give Black. White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: 3 K Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Chauncey Mankin Marie Burkardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine C. Reals (Daughter) 17715 Doctor Walling Rd., Poolesville, MD 20837 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Derrial 2 Cremation 3 Removal from State Memory Gardens 9/5/2012 Colonie, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libensees 22. Name and Address of Facility Metropolitan Funeral Service Mun 5517 Vine Street, Alexandria, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition ONT 4 ecu Medical Due to (or as a consequence of): Examiner Sequentialfy list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): within 24 hours effer deeth.

To the Funerel Director: After this certificete hes been signed by the ettending physicien end completely filled in by the funerel director, pege 2 should be deteched for use as the buriel-trensit Hospitel or Attending Physicien: The lew requires thet the death certificete be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 2 No I ☐ Yes 2 🗓 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) ZOV Me

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

30

2012

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 23 Day Physician/ Month 2012<sup>ye</sup> Robinson August 3:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's 716 Audrey Lane Oxon Hill . Social Security Number 8. Date of Birth
Sept. 12, 1945

9. Birthplace (State or Foreign
Country)
Carolina If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 - F Hours 248-74-6810 Director 66 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 716 Audrey Lane 20745 U.S.A. Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 2. Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or ite Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bert Robinson, Sr. Icelean Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Carrigan Ct., Florence, SC 29505 Omijean Sanders Department of Healt Important: If item 2 any injury or other I 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory of 1 X Buriel 2 Cremation 3 Removal from State Florence Nat'l Cemetery 8/29/2012 Florence, SC 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Netropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cardiovascular Heart Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypolipidemia Sequentially list conditions, if any, Lucing 1 immediate cause. Enter Underlying Cause (Disease or iinjury Examine for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical death certificate be P,O, Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No death? ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 2 1 ☐ Yes 2 🖾 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Accrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

J

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Crystal Yeldell, M.D.

2012

31. Date filed (Month, Day, Year)

D50348

5100 Auth Way., Suitland, MD 20746

Aug. 28, 2012

12-06473 Patr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ricia Rich		1- For State	State	of Maryl		Depa	artment o rtificate o	f Healt	h and	Ment	al Hy		gibic	2	01	2	278
Physici	an/	Registrar  1. Decedent's Name (First, N	iddle,Las	st)			imouto o	Doda	•			. Date of De			3.	Time o	f Death
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		Upper Chesapeake	Medic	cal Center				Bel Ai	r				Ha	arford			
Funeral		5. Social Security Number	6. S	ex	7. Age	(In yrs. I	ast birthday)	If Unde	r 1 Year Days	If Under Hours	24Hrs. Min.	8. Date of B	irth(MM/D	DYYYY	9. Birthp	lace (St	ate or
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vithin ene.	Completed	12			1		PHLE	BOTOM						UCMC			
filed v Hygi doth		17. Father's Name (First, Mid	dle, Last	2)					18.	.Mother's		irst, Middle,		urname)			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner, must be notified at once.	To Be	JOSEPH MISTRE  19a. Informant's Name/Relati		Type Print )			19h Mailin	n Address	(Street a	and Numb		LELLO al Route Nu		or Town	State 7i	n Code	
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Medical Examiner		Immediate Cause Final dise		Hypertensi	ve Ath	eroscl	erotic Card	iovascul	ar Disea	ase							Death
LXummer		or condition resulting in deat	٦)	Due to (or as a	consec	quence o	f):					·					
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b.	Due to (or as a	consec	uence o	f):										
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Box 68760 e death certificate b the attending physical for use as the bu	Physician/Me	1 Yes 2 No 9 ✔	Unknowr			me of de	ath 5 Ot	her (Speci	ify)								
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Re iffcate r, pag		25. Was case referred to med	lical [					20	6.Place of	Death (C	beck on		2 <b>✓</b> No	1	Yes	2	No
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  11 Director: After this certificate has been siled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	ertificati		vestigati ould not	28e Plac	e of Inju	ry - At ho	ome, farm, stre	et, factory,	office build	ding, etc.	28	f. Location (		Number	or Rural	Route N	umber, City
Division or At ours after doeral Direct filled in by	Cer	4 Homicide	etermine	d (Specify)								OI TOWII,	State)				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Fuorata Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	g	29a. Certifier 1 Certifying one) 2 Medical I		ian: To the bes												ause/s\	
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		Zabiullah Ali, M.D.		stant Medic		•		altimore	Street,	, Baltim	nore, M	D 21223					
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Regist	rar	AUG 3 0 201	2 /	kneer	Ø.	19	ale										

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 06-2011

State Registrar

29b. Signature and title of certifier

tan

30. Name and address of person who completes

Franklin Square Drive Baltimore mo

cause of death (Item 23a) (Type, Print) 9000

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27856 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marjorie H. Rhoades August 2012 11:50 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Broadmead Cockeysville Baltimore Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 444-14-6610 91 **Director** February 1 □ M 2**X** F Branx, New York Usual Residence of Decede 1921 show or 28a-f shown notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Cockeysville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country?
United States Funeral 13801 York Road Unit H266 21030 of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married by 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. white Completed 3X Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Colorado State Elementary/Secondary (0-12) College (1-4 or 5+) Librarian University Ith and Mental Hygien 27 is marked other the traumatic event, the 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard A. Hoffman Grace May Deeves Page 1 and 2 should ment of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Stuart/son 27 Altamonte Springs, Florida 1136 Pearl View Dr. other Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial ACCremation 3 Removal from State cemetery cranatory or other place, Evans Funeral Chapel – Bel Air August 28, 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2012 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. Timonium, Maryland 2325 York Road 23a. Part 1. Enter the diseashock, or heart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CON disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed the attending physician and burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continute to the cause of death? Completed by or Attending Physician; The law requires 1 Yes 2 Line 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s after death.

Director: After this certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 2 No 1 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Mann J of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No filled in by the ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

### 12-06119 Lynn Sue Roussey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 27857

		1- For State Registrar	C	ertificate o	f Death		Reg	. No.	2 2100	
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	Lynn Sue Ro	ussey			2. Date of Death Month 1 August 15,	Day Year 2012	3. Time of Death 0819 hrs	
		4a. Facility Name (if not institution, give str 1941 Apt H Edgewater Drive			4b. City, Town, o	or Location of Deat	h	4c. County of Death Harford		
Funeral Director		5. Social Security Number 6. Sex 207-58-5472 1 M  Usual Residence of Decedent		s. last birthday) 49 yr.	If Under 1 Ye Months Da		<b></b>	Foreign	nplace (State or n ntryMaryland	
id how any cc.		10a. State 10b. County  MD Harfo		ity, Town or Loca	tion	Edgewood			10d. Inside City Limits  1 X Yes 2 No	
the Maryland a or 28a-f show	Director	10e. Street and Number 1941 Apt. H Edgewater D			10f. Zip Code	21040		. Citizen of What Coun		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 1	. Was Decedent Ever in Armed Forces?  Yes 2 X No	, If '	Yes, specify Cuba	lispanic Origin? ( S an, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black, White	
5 72 hours afte n "natural", al Examiner	eted by	15. Decedent's Education (Specify only harmonic Elementary/Secondary (0-12)	Dates:	16a. Decede	nt's Usual Occup nost of working lif	ation (Give kind of e. DO NOT use ret	16b. Kind of Business/Ir	ndustry		
MD 21215-0036 at 2 should be filed within 7 at the and Mental Hygiene. m 27 is marked other than a marke event, the Medical	Completed	12 17. Father's Name (First, Middle, Last)				Jnkn. 18.Mother's Name	e (First, Middle, Ma		ıkn.	
21215 Ild be file Mental H. Marked o event, til	To Be (	Josep.  19a. Informant's Name/Relationship (Type	edwin Roussey		na Address (Stra	et and Number or		erna Knopp er, City or Town, State,	Zip Code)	
MD Shot alth and I saumatic		Amber Rose Roussey / D	aughter		t. E Hanove	er Street, Abe	erdeen, MD 2	21001		
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Chesapea		ory 8/	30/2012	20c. Location - City or T Beltsvi		
		Dorota Marshall	le il leau	well N	Maryland Cı	remation Ser		ox 1413 Baltimo		
Physician /Medical Examiner				Cardiov			or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death	
	e.	Sequentially list conditions, b	to (or as a consequence	,						
d sit	Examine	(Disease or injury that initiated	to (or as a consequence	e of):						
760, icate be executed physician and the burial - transit	Medical E	d.  X UNPENDED A	MENDED 23a, pt.	II,27,p	er me,g9	31 9-6-1	2 sm			
DX 68 ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown	3c. If yes, outcome of pro Live birth Pregnant at time of Unknown	2 F6	etal death 3 ther (Specify)	Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year	
i, P.O. Beires that the designed by the signed by the sibe detached fr	ã	Part II. Other significant conditions con Diabetes Mellitus	tributing to death but no	t resulting in the	underlying cause	given in Part I.		acco use contribute to the		
Division of Vital Records, talor Attending Physician: The law require rs after death.  31 Director: After this certificate has been sited in by the funeral director, page 2 should b	Completed						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of	
Vital Rec ysician: The l his certificate b director, page	B	25. Was case referred to medical examiner?	ital: 1 Inpatient 2	ER/Outpatien		e of Death (Check		esidence 6 🗸 Other:	Scene	
ion of V tending Phy leath. tor: After th	ation: To	1 ✓ Yes 2 No  27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day,Year)	28b. Time of	Injury 28c. Inj	ury at Work? Yes 2 No	28d. Describe ho		COCITO	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	1   Natural   2   Accident   3   Suicide   4   Homicide   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On	To the best of my knowle the basis of examination manner stated.							
	ž	29b. Signature and title of certifier				se number		29d. Date signed <i>(Mon</i> August 15, 2012	th, Day,Year)	
Ø			Medical Evamine	- 900 W/ B	altimore Stre	et, Baltimore,	MD 21223			
St Regist	ate	31. Date filed (Month 2012 Pr)	32. Registrer's Sign	A RUCE						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departi				07050					
_			Registrar  1. Decedent's Name (First, Middle, Last)	icate of Death		g. No. 2012						
	Physicia Medic		Kofi Safo		2. Date of Death Month August	9 Day 2012 Year	3. Time of Death 7:20 AM M					
Y	Examin		4a. Facility Name (if not institution, give street and number)  Scotland Manor Assisted Living	c. City, Town, or Location of Death Baltimore		4c. County of Death						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthp	blace (State or Foreign					
	Director		282-42-0368 1 XM 2 F / V Yrs.	onths Days Hours Min.	(Month, Day, Y	(ear) Coun	try)					
7	show	ا <sub>ة</sub> ا	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		June 24,		ana Od. Inside City Limits					
Manyla	waryie 28a-f s tified	Director	MD Baltimore	<u>}</u>			1 X Yes 2 ☐ No					
<del>+</del>	3a or 2	al Di	10e. Street and Number 1 2900 Boarman Ave.	0f. Zip Code 21215	10	g. Citizen of What Coun	try?					
ath wi	ems 2	Funeral		Decedent of Hispanic Origin? (Spec	city Yes or No-	14. Race - Americ	an Indian					
ဋ္ဌ	", or it	by F	1 ☑ Never Married 2 ☐ Married Armed Forces?  1 ☐ Yes 2 ☑ No	s, specify Cuban, Mexican, Puerto F Yes 2 🔯 No Specify:	Rican, etc.)	Black, White, e	etc.					
0	atural cal Ex	eted	3 □ Wildowed 4 □ Divorced Year or Dates.	's Usual Occupation unk	T.		1110 /2					
215	hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by	(Give kind Elementary/Secondary (0-12) College (1-4 or 5+)	of work done during most of workir OT use retired)	ng 1	6b. Kind of Business/Ind	dustry					
ط ا	Hygier other t	Be C	unk unk  17. Father's Name (First, Middle, Last)	18. Mother's Name	(First Middle Ma	iden Surname)						
/lan	Mental arked c	2	Kwame Doudu	Amma Se		iden Samane)						
, Mary	alth and h		19a. Informant's Name/Relationship (Type, Print) Yaa Sofi - brother  19b. Mailing Ac 2040	ddress (Street and Number or Rura) Bruckner Blvd #	Route Number, C 14E; Bro	ity or Town, State, Zip C nx, NY 1047	73					
Baltimore, Maryland 21215-0036	perment of Health and Menta Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5 Other (Specify) in state		Date 20	0c. Location - City or To	wn, State					
Balti	Departn Importa any inju		21. Sign for Funeral Servi License Director	ame and Address of Facility Sta		-	21201					
			23a. Part L. Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause an each line.				Approximate Interval Between					
	n sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a			Onset and Death					
	xaminer		Due to (or as a consequence of):									
		iner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying	Due to (or as a co. sequence of,								
<b>3</b> be executed	and -transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):									
<b>60</b> Ite be ex	siciar	dical	d									
<b>6876</b> ertificate	ngph) asth	Med	IF FEMALE:									
Records, P.O. Box 6876( The law requires that the death certificate	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 \subseteq Live Birth 2 \subseteq Fetal death 3 \subseteq Ec	topic pregnancy her (specify)		23d. Date of delive Month	ory Day Year					
P.O.	gned by be detai	by Pł	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?					
rds, equire	een si	eted	Dernstexta			2 No 3 Prob						
Records, The law requires	ate has page 2	Completed			24a. Was an autopsy performe	prior to cor death?	osy findings available inpletion of cause of 2 No					
ital sician:	certific irector,	Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   Inpution 2   ED/Outpution 3	26. Place of Death (Check								
of V	er this neral d	e: To	27. Manner of Peath 28a. Date of injury 28b. Time of	28c. Injury at 2	ne 5 Desidend 8d. Describe how	ce 6 Other (Specify) injury occurred						
On	eath. or: Aft the fur	ificat	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No								
Division of Vital	within 24 hours after death.  To the Funeral Director: After this certific, completely filled in by the funeral director,	Certificate:	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,					
L lospita	4 hours uneral ely fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu (Check 2 Medical Examiner: On the basis of examination and/or investigation	rred at the time, date and place, an	d due to the cause	e(s) and manner as state	ed.					
o the l	ithin 2 o the F omplet	Me	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, dea 29b. Signature and title of certifier	th occurred at the time, date and place 29c. License number	ce, and due to the	cause(s) and manner as s	tated.					
	s <b>⊢</b> 0		Aul Weeri mD	D2674	8	8 24/5	2012					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ALLS RP	BAI	70 M	1466					
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 3 0 2012  32 Registrar's Signature	<u> </u>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 11:20 PM Emery Lee Staton Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Envoy of Denton Denton . Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Min (Month, Day, Year) 216-42-7821 67 Director 1 🖾 M 2 🗆 F 1944 Maryland Sept 13, 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 🗌 Yes 2 🖺 No Caroline Denton 10e, Street and Number ō 10f. Zip Code Citizen of What Country? USA items 23a 21629 538 N. 6th St. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) automotive mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Dorothy Elizabeth Weitzel ဂ္ Emery Lee Staton Sr. 19a. Informant's Name/Relationship (Type, Print, Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 1825 Halltown Rd; Harthey, DE 19953 Victoria Staton - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signat in of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final · Physician/ ar un disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Id be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 1 L Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has ral director, page 2 autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ᇛ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural
Accident 5 Pending injury work?
1 Yes 2 No n 24 hours after death.

Funeral Director: A letely filled in by the fu Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D37036

State Registrar 30. Name and address of person who

31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

ompleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 25, 2012 Maryterese Catherine Streett 9:28 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Forest Hill Senator Bob Hooper House 5. Social Security Number 173-24-7944 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** 1 □ M 2 🛣 F 81 Sep. 4, 1930 Pennsylvania Usual Residence of Deceden 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 404 W. Gordon Street 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဪNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Itimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Sales Associate Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Michael Ryan Mary Rosaria Durkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 W. Gordon St., Bel Air, Maryland 21014 Eugene Streett / Spøuse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 St Burial 2 Cremation 3 R 4 D Conation 5 D Other (Specify) cemetery, crematory or other place, moval from State Deer Creek Meth. Cem. 8-30-2012 Forest Hill, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sid are of Funer 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the dis ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \subseteq Yes 2 \subseteq No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowled je, death occurred at the time, date and place, and due to the cause(s) and manner as also and place. (Check 29b. Signature and use of death (Item 23a) (Type, Print) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar			d / Depa		f Health	n and N	Mental Hyg	_	210	27861
	Physicia	n/	1. Decedent's Name (First, Midd							Date of Dea     Month	th Day	Year	3. Time of Death
	Medic	al	Lois  4a. Facility Name (if not institution		ıllivar	n	41. 02. 7.			Augus		2012	5:37 A M
	Examin	er		gional Hospi	- 1		4b. City, Town	n, or Location dure	1		4c. County	of Death	eorge's
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	ast birthday)	If Under 1 Ye		ler 24 Hrs. Min.	8. Date of Birth	1		lace (State or Foreign
	Director		417-24-2636 Usual Residence of Decedent	1 □ M 2 🔀 F	87	Yrs.		7 1.00.0		Nov. 19		Alab	**
	and show	tor	10a. State 10b. Count		10c. Cit	y, Town or Lo	cation				, 1351		0d. Inside City Limits
	Mary 28a-f otifie	Director		ce George's	Ве	eltsvil	le						1 🗌 Yes 2 🅱 No
	th the 3a or t be n	ralD	10e. Street and Number				10f. Zip Coc				10g. Citizen of \		try?
	ath wi	Funeral	7516 Burdett	12. Was Deceder	nt Ever in U.S	3 13 1	2070		Origin? (Spe	cify Ves or No-		USA	an Institut
9	ter de , or it	by	1 ☐ Never Married 2 ☐ Ma	Armed Force 1 Yes 2	s?					cify Yes or No- Rican, etc.)		e - America ck, White, e	
8	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ted	3 X Widowed 4 ☐ Divorce	fear of Dates	S.		Yes 2 🔀	No Speci	ify:		Specify:	W	hite
21215-0036	72 ho n "na Aedio	Completed	(Specify only high	dent's Education ghest grade completed)		(Give	lent's Usual Oc kind of work do O NOT use retir	ne during m	ost of worki	ing	16b. Kind of B	usiness/Ind	lustry
212	within 73 giene. <b>er than</b> , the Me		Elementary/Secondary (0-12)	2) College (1-4 o	or 5+)		entive	,			U.S. S	teel	Corp.
pu	filed tal Hy d oth	To Be	17. Father's Name (First, Middle,	, Last)				18. Mo	ther's Name	e (First, Middle, I	Maiden Surname	9)	
yla	should be file and Mental I is marked c	ř	Rodney Willia						Octav	ia Self			
Maryland	2 shoth and the and 27 is rutaur		19a. Informant's Name/Relation: Dorothy Sulli		~		_			l Route Number, eltsvili			ode)
re,	1 and of Hea item other		20a. Method of Disposition		20b. F	lace of Dispo	sition (Name of			Date	20c. Location -		wn, State
imo	Page nent c ant: If ury or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	in 3 $\square$ Removal from Star (Specify)		-	natory or other p		9/8/	2012	Birming	ham.	AL
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Elicensee		22	. Name and Ad	dress of Fac		naldson	Funera		
	40 = 8 0		23a. Part I. Enter the disease, of	, Laur		2070	_						
- Mary	Physician/ Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a Obs	truct	ive s	Sleep			r respiratory arre	951,		Approximate Interval Between Onset and Death
	Examiner			Due to (or a	as a consequ	uence of):		'					
	uted d ansit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a	as a consequ	uence of):		···					
	e be executed ysician and ne burial-transit	sat Ex	resulting in death) Last	Due to (or a	as a consequ	uence of):							
68760	ficate I g phys			d								土	
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total states.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcor 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	th 2 🗌 Feta nt at time of c	al death 3 🗌	Ectopic pregn Other (specify				1	te of delive onth	ry Day Year
P.O.	at the	, Phy	9 ☐ Unknown  Part II. Other significant condit			ulting in the u	nderlying cause	given in Pa	ırt I.	23e Did to	bacco use contr	ribute to th	e cause of death?
	requires that the des been signed by the s should be detached	d b	Hypertens	ion									ably 4 Unknown
orc	iw requ	plet	Diabetes							24a. Was a		Were autop	sy findings available inpletion of cause of
Rec	The law ate has page 2	Com								autop: perfor 1 \(\sum \) Yes	med?/	death?	
ital	Physician: The this certificate al director, pag	To Be	25. Was case referred to medica examiner?	Hoopital				. Place of De	eath (Check				
of V	Phys r this e	e: To	1 Yes 2 No 27. Manner of Death	1 🛂 Inp		ER/Outpatier 28b. Time of	t 3 🗆 DOA			me 5  Reside			
ou c	ath. r: Afte	icat		ding (Month, I stigation	Day, Year)	injury	M 1	njury at /ork? Yes 2		zod. Describe   (	ow injury occurre	3G	
Division of Vital Records,	or Atter fter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	rmined 28e. Place of	Injury - At ho etc. (Specify		et, factory, offic	ce		28f. Location (St		er or Rural	Route Number,
۵	spital o	cal (	29a. Certifier 1 Certifyin	ng Physician: To the best	of my knowl	edge death o	occurred at the	time date a	nd place ar	nd due to the ca	see(e) and mann	nor as state	d
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 \( \subseteq \text{Medical} \)	I Examiner: On the basis on the David of the	of examination	n and/or invest	igation, in my or	pinion, death	occurred at	the time, date an	nd place, and due	e to the cau	se(s) and manner stated.
	Not with		29b. Signature and title of certifie	ier tho K	10			700°		2	29d. Date signed	1 (Month, D	ay, Year)
	6		30. Name and address of person	n who completed cause o	of death (Item	23a) (Type, P	win A)			7300	Van Di	usen	Road
	グ		Saritha Gora	intla, MD	Lau	rel Re	giona	Hasp	oital	Laur	Van Di el, Mo	D:	20707
	Stat Registra		31. Date filed (Month, Đay, Year)  AUG 3 (	0 2012	strar's Signat	d. Ja	ale						

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and State Registrar  State of Maryland / Department of Health and Certificate of Death	d Mental Hy	giene Reg. No. 20	12 27862
			1. Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physicia Medic		JOSEPH MICHAEL SPENARD JR.	AUGUST	2 <sup>Day</sup> 201	
	Examin		4a. Facility Name (if not institution, give street and number)  PRINCE GEORGE'S HOSPITAL  4b. City, Town, or Location of De	eath	4c. County of PRINCE	Death GEORGE S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If Months Days Hours M	Hrs. 8. Date of Bir Min. (Month, Da		. Birthplace (State or Foreign Country)
	Director		212-72-3452 1 XM 2 □ F 54 Yrs. World's Days Hours W	MARCH	7 1958 1	WASHINGTON, DC
	yland f shov ed at	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	r 28a- notifi	Dire	MD PRINCE GEORGE'S BLADENSBURG  10e. Street and Number 10f. Zip Code			1 X Yes 2 □ No
	th with the ms 23a commust be	neral	4663 RED HAWK TERRACE 20710		10g. Citizen of Wha	at Country?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	? (Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc. BLACK
1215-(	thin 72 hou sne. than "nate he Medica	Somplet	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th  15. Decedent's Education (Give kind of work done during most of ville. Do NOT use retired)  LANDSCAPER	working	16b. Kind of Busin	ess/Industry
0	should be filed within 7; and Mental Hygiene. is marked other than aumatic event, the Me	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's I	Name (First, Middle, BETH SIMM)	Maiden Surname)	
lary	should be file h and Mental I 7 is marked c traumatic eve		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			
ė, Z	and 2: Health tem 27 other tr		JOSEPH M. SPENARD SR./FATHER 4663 REDHAWK TERRACT	E BLADENS	BURG, MARY	
D E	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  RIVERDALE CREMATORY 8/:			E, MARYLAND
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  7474 LANDOVER ROA	J.B. JENK	INS FUNER	AL HOME, INC.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or fleat failure. List only one cause on each line.			Approximate Interval Between
~ P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Fata Cardiac Arrythmic	4		Onset and Death
) <sup>4</sup>	Examiner		Preumocacal Preumonia and	d Sepsi-	2	
	sit d	Examiner	Sequentially list conditions, D. Due to (or as a consequence of):  cause. Enter Underlying			
Ó	xecute and al-trans	Exan	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
) 03 (	ate be executed physician and the burial-transit	dical	d			
289	ertifica ding ph	/Me	FFEMALE: 23c. If yes, outcome of pregnancy			1
Box (	that the death certilicate be executed ned by the attending physician and e detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1		23d. Date o Month	f delivery Day Year
О	es that the dea igned by the a be detached f	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
rds.	equire een si hould I	eted	HIV	_ 1 🗆 '	Yes 2□No 3[	Probably 4 Unknown
Records,	the law late has bage 2 s	Completed		— 24a. Was autop perfo 1 □ Yes	osy prior deat	e autopsy findings available r to completion of cause of th? Yes 2 No
Į.	cran: ertifica ector,		25. Was case referred to medical examiner?  Hospital:  Other		201101 10	1100 2 2 1100
<u> </u>	Pnysi rthis c eral dir	일 :		ng Home 5 Resid		Specify)
ouc !	nding ath. r: After re fune	icate	1 Matural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M I ☐ Yes 2 ☐ No		ow injury occurred	
Division of Vital	ral or Arters as after de al Directo ed in by the	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		r Rural Route Number,
1	to the hospital or turdening Pnysician: The law requires, within 24 hours after death.  To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of my knowledge, death occurred at the time, date and place to the date of the date of my knowledge, death occurred at the time, date and place to the date of the da	red at the time, date a	nd place, and due to	the cause(s) and manner stated.
	o o o o		29b. Signature and title of certifier foliage. M. b. 29c. License number 29c. License	6	29d. Date signed (M	-
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Plint)  JAGLER INGH 3001 HIS DITAL DR (	Chevir	lu mo	20785
	Stat Registra	e	31. Date filed (Month, Day Year) AUG 3 0 2012  22. Registrar's Signature		1	
	H 17 Pov 06-2		made the summer of garden			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 08 Day 18 Ellen 7:080 Medical 4a. Facility Name (if not institution, give street and number **Examiner Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours **Director** 02-23-1914 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Capitol 1'X Yes 2 \( \text{No}\) 10e. Street and Number 10g. Citizen of What Country? Funeral USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ★Widowed 4 □ Divorced Completed Specify: Black Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) lerk Be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) greatniece 20b. Place of Disposition (Name of 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Domation 5 Other (Specify) andover, MD 4594 Beech Temple itills MO20748 or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease Approximate Interval Between Onset and Death or heart failure. Li Immediate Cause (Final Physician/ disease or condition resulting in death) S 95 Medical Examiner 2004 Sequentially list conditions, if any, leading to manuscrite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-tran and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 — Live Birth 2 — Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ retail 2 ⊆ 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year signed by the at Id be detached for 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascu Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Blindness Demen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 2 Acciden 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) D31001 8/20/2012 70 eted cause of death (Item 23a) (Type, Print) 7500 Greenway Cate. Dr. 80. Name and address of person who co

Registrar DHMH 17 Rev 06-2011

State

Greenbelt,

MD.

sewi

2012

32. Registrar's Signatur

2-06383 Carl Selby, Jr.		Please Type State	or Print in E of Maryland				•		egible.		
, and a constant of the		1- For State Registrar	or waryland		tificate of		a Mentari		Reg. No.	2012	2788
Physici Medical Exami	an/	Decedent's Name (First, Middle,La     CARL SELBY, JR	•		_			2. Date of De Month August 2	ath	ear 3.	Time of Death 1200 hrs
1		4a. Facility Name (if not institution, g		er)		b. City, Town, or I	Location of Dea			y of Death	
		909 Nottingham Road Ap				Baltimore				N/A	
Funeral Director				Age (In yrs. Ia		If Under 1 Year Months Days		in.	Birth(MM/DD/YYY	Foreign	
Director.		217-66-7413 1 Usual Residence of Decedent	<b>X</b> M 2 F	57	Yrs.			11-11	<del>-1954</del>	Countr	MARYLAND
Any		10a. State 10b. County		10c. City,	Town or Locati	on				10	d. Inside City Limits
yland •-f show	5	MD N/	A		BALTIM	ORE				1	Yes 2 No
Maryl • 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V		?
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once.		909 NOTTINGHAM R			0 140 114	21229			USA		District District
ath wi	Funeral	11. Marital Status  1 X Never Married 2 Marrie	12. Was Decede	s?		Decedent of Hisp es, specify Cuban,				ce - American site, etc.	Indian, Black,
fter de		3 Widowed 4 Divorce	Yes d If Yes, Give Year	2 No	1	Yes 2 X No	specify:		Specify	WHIT	E
tours a	ad be	15. Decedent's Education (Specify	only highest grade c	ompleted)		's Usual Occupati			16b. Kind of E	Business/Indu	ıstry
2	plet	Elementary/Secondary (0-12)	College (1-4 o	r 5+)		MAN HELI			PRIN	TING	
5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin	Completed	17. Father's Name (First, Middle, Las	st)	1	TRIBU		* Marting Comment	ne (First, Middle,	, Maiden Surnam		
	Be	CARL A. SELBY.S	R.				CAROL 1	FOSTER			
O 8 5 3 4	٤	19a. Informant's Name/Relationship	(Type, Print )		19b. Mailing	Address (Street			umber, City or To	own, State, Zij	p Code)
2 78 8 78		DONALD SELBY  20a. Method of Disposition	<u>B</u>	ROTHER	7513	WALSTON	SWITCI	ROAD Date		T - City or Tox	D. 21849
Baltimore, Normit. Pages I and Department of Health Important: If item injury or other frau		1 X Burial 2 Cremation 3	Removal from		rematory or oth		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	54.0	200. 2004.00		, 0.2.0
Baltimo permit. Page Department of Important: injury or oth	-	4 Donation 5 Other Specification Specification of Puneral Service Lice		GAR	DENS OF	FAITH ame and Address	of Facility	L-2012	BALTIM	ORE. M	D
Dep. Dep.		This			6/	15 BELAT	UVUA AI	LLEK-DIE RAT.TT	MORE. M	EKAL H	IOME, INC.
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on		d the death.	Do not enter th	e mode of dying,	such as cardiad	or respiratory as	rrest, shock, or h	neart A	Approximate Interval Between Onset and
Medital Examiner	ı	Immediate Cause (Final disease	Atherosc]			ovascula	r Disea	se			Death
,		or condition resulting in death)	Due to (or as a cor	sequence of	):						
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	sequence of	):						
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executed an and al-transit	ical Examiner										
ox 68760, and certificate be executed attending physician and or use as the burial - transi		▼ UNPENDED	AMENDED238	,pt.I	I,27,pe	r me,g93	1_9-6-1	2 sm			
376( ificate ig phys s the b	N/L	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	ome of pregr		al death 3	Ectopic pregi	nancv	23d. Date of Month	of delivery Day	Year
Box 68760, to death certificate be extending physicial ed for use as the burial	icia	past 12 months?	4 Pregnant	at time of dea		er (Specify)				,	
W 2 5 2	Physician/Med	Part II. Other significant conditions	9 Unknown		and the same	- d- d, d	ives is Deat I	Loop Did	tobacco use con	tribute to the	course of death?
de de de		Chronic Alcohol	•	ath but not re	suiting in the u	ideriying cause gi	iven in Part I.				y 4 V Unknown
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of Vital Records, og Physician: The law requir Nêr this certificate has been s meral director, page 2 should		25. Was case referred to medical		_		26.Place	of Death (Chec		2 No	1 Yes	2 No
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2	ER/Outpatient		Oth		Residence 6	✔ Other: So	ene
ing Ph After t funeral		27. Manner of Death	28a. Date of Ir (Month, Day	njury r,Year)	28b. Time of In	· ·   ·	y at Work?	28d. Describe	how injury occu	irred	
	Satio	Natural 5 Pending Accident Investiga					es 2 No				
Division  To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could no determin	t be	Injury - At ho	me, farm, stree	t, factory, office bu	uilding, etc.	or Town,		iber or Rural I	Route Number, City
Divi		4 Homicide  29a. Certifier (Check only 1 Certifying Physical Check on Check	clan: To the best of	mv knowledo	e. death occurr	ed at the time, dat	te and place, ar	nd due to the cau	use(s) and mann	er as stated.	
To the Hos within 24 h To the Fur completely	Medical	(5.1.5.51.7)	er: On the basis of ex	amination ar							ause(s)
F 3 F 5	ž	29b. Signature and title of certifier	D	20		29c. License	number		29d. Date sig	ned (Month,	Day, Year)
		Pot a	[6	ller		O.C.N	л.Е.		August 25	5, 2012	
6		30. Name and address of person who Patricia Aronica-Pollak M				900 W. Baltim	ore Street	Baltimore M	MD 21223		
S	ate	31. Date filed (Month, Day, Year)		rar's Signatu			.5.0 01.001,				
Regist		AUG 3 0 2012	1	1 6	west						
DHMH 17 Rev 1/2	001	00	OME	7	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:15am Jean Segal Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomeru Birthplace (State or Foreign Country) Social Security Number Year If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Hours 95 327-14-2123 Director 1 □ M 2 🛣 F April 06.1917 New York Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Rockville Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6105 Montrose Road 20850 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ဂ္ Abraham Finkelstein Ethel Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Jonathan Segal - Son 2513 Spencer Road, Silver Spring, Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Adat Shalom Mem Park | 08/24/2012 | Livonia, Michigan 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 232 11800 New Hampshire Ave., Silver Spring, MD 20904 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rijury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to A hours after death.

Funeral Director, After this certificate has been signed by the attending newsivia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the shed for signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the Pwithin 2 To the P only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-22-2012 hin D00648 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2012

6121

32. Registrar's Signature

Rockville

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUGUST 11:45P MARVIN LEE SACHS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth (Month, Day, Year) Days Hours Min Director 214-26-8645 1 🛛 M 2 🗆 F 83 05/07/1929 MD Usual Residence of Decedent "naturel", or Items 23e or 28e-f show filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 406 OLD CROSSING DRIVE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates the Madical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) SALES REAL ESTATE Be traumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ဂ္ permit, Pege 1 end 2 should be f Department of Health and Menta Importent: If item 27 is marked SAMUEL SACHS IRENE KRAVITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN SACHS / WIFE 406 OLD CROSSING DRIVE, BALTIMORE, MD 21208 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Importent: If it eny injury or o cemetery cometory of other place). ARLINGTON CEMETER CHIZUK AMUNO CONG 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/29/2012 BALTIMORE, MD ature of Funeral Service Licen ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dement Physician disease or condition resulting in death) W Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The lew requires that the death certificate be executed ause (Disease or rigul) cate hes been signed by the ettending physicien and pege 2 should be detached for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No death? After this certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 D Other (Specify Hospital: 2 No မှ 1 🗌 Yes DSPLCI 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signate and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOW SON MO MARRA 31. Date filed (Month, Day Year State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 &16b Per FH G930 8/30/2012 Jh State of Maryland Department of Health and Mental Hygiene amend #17, per fn, 8/32 to 16 Per FH G932 Sm Department of Health and Mental Hygiene Fine 1932 10-11-112 sm Mental Hygiene Certificate of Death State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day SAUNDERS 21 WINDELL 1830 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SECOURS HOSPITAL BALT BALTIMORE MP Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M M 2 🗆 Hours Min. 219-22-8210 Director MD Usual Residence of Decedent or 28a-f show 10b. County should be filed within 72 hours after death with the Maryland 10c. City Town or Location Examiner must be notified at 10d. Inside City Limits Director AH: mere 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ■ Yes 2 □ No o. Black, White etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 1 ☐ Yes 🎾 No Specify. ach If Yes, Give 3 Widowed 4 Divorced 1950 Year or Dates. 15. Decedent's Education Achen's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafarer Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Niddle, Maiden Surname) George Saunders Anie 8 ၉ Informant's N e/Relationship (Type, Print) 19b. Mailing Addys 140 nders 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other ACP!SON ation 5 Other (Specify) of Funeral Service Licensee Signature fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to as a conseque Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). as the burial-trans Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 L 9 Unknown detached 9 Unknown us been signed by the should be detached Part II. Other significant ponditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 diknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Be 25. Was cas referred to medical 26. Place of Death (Check only one) Other: ည Outpatient 3 DOA 1 🗌 Inpatient 2 🛭 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of De 28a. Date of injury (Month, Day, Year) of Death 28b . Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). BATT 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 140 PM 2012 Medical 4a. Facility Name (if **Examiner** not institution, give street 4c. County of Death 4b. City, Town, or Location of Death B1/7/170 YC BILTIADIE N/A 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** unk 1 □ M 2 🔀 F Months Hours Min. N. Carolina 0970271934 Director 76 Usual Residence of Decedent 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified N/A MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2768 Kinsey Ave. 21223 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Garment Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Talmadge Stokes Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 Woodgreen Cir., Baltimore, MD 21207 Victor Alvin Faison(son) Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
On-site Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 7-12 Baltimore, MD 4 Donation 5 Other (Specify) Sic nature of Service Li 2140 N. Fulton Ave., Baltimore, MD 21217 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heard allure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Onset and Death Pnysician/ isease or condition resulting in death) -17-101 SNIC DIV Medical Due to (or as a conseque ve of) Examiner Secuentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) CENTIFICATION APPROVED BY MEDICAL EXAM Examir use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be CIII Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) Day Year 1 Yes 2 s been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▶ No 24a. Was an certificate has page 2 autopsy perform filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of injury (Month Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 2. Accident injury work? 5 Pending LATISTRY death. 2 **1** No cacy to Direviting Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State HOLAITE BAITHOU 2066 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 3 29b. Signature a 29d. Date signed (Month, Day, Year) 011/1/24 e and address of person who completed cause of death (Item 23a) (Type, Print) 2000 LOIN 10811 Seltinose

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) AUG 3 0

Karo 6	David Smith
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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and the same of th		Rear of 12445 Ocean				Ocean						Vorcester			
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Division of Vital Records, P.O. Box 6876( the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phys physicial in by the funeral director, page 2 should be detached for use as the b	Certification:	dete	d not be 28e. Place of In (Specify)	ijury - At h Fiel	ome, farm, stree	et, factory, o	ffice bui	ilding, etc.	0	or Town, S cean C	street tate)	and Number [2445 C	cea	Route Number, <b>n Gatew</b> a	ay
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		<ol> <li>Name and address of person Ana Rubio M.D., Ph. I</li> </ol>				W. Baltii	nore (	Street, E	Baltimo	ore, MD 21	223				
Sta	17.0	31. Date filed (Month, Day, Year)	2. Registra	r's Signati											$\dashv$
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29 2012 6:33 a John Andrew Teano Aug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Upper Chesapeake Hospital Harford Belair If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, . Social Security Number **Funeral** 1 ☐ M 2 ☐ F June 18 1925 MD 212-20-2330 Director Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 1 Yes 2 No Director MD Baltimore Timonium 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 512 Limerick Circle #204 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 43-45 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility/BGE 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Joseph Teano Marie Nooney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2221 Eastridge Rd., Timonium, MD 21093 Janice A. McGarvey/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/31/12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Lemmon Funeral Home of Dulaney VAlley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myoCardia \*Physician disease or condition resulting in death) /Medical Due to (or as of nsequence of): Examiner AD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOO 63220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE ISKUA RUS

500 MPPER CHESAPEAKE DR. BECAIR, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #3&23e Per PHY &7&16b Per FH G931 9/07/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:09 P Physician/ Month Ruth Millicent Hamilton Vecchione August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Hampton Meadows
ocial Security Number 6. Sex <u> Fowson</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, April, 9. Birthplace (State or Foreign County) England **Funeral** 1 M 2 F Months Days Min. Hours 218-32-7454 <del>68</del> 88 Yrs Director 1924 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Monkton 1 ☐ Yes 2 🛛 No Maryland Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 16339 Falls Road 21111 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Entertainment and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **Industr**v Opera & Classical Singer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked Gavin John Hamilton Olive Muriel Appleby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Diana Μ. Amrhein Daughter 10 Edgemoor Road Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dutatiev reverbly brether place injury or Memorial Gardens Donation 5 Cher (Specify) 9-1-2012 Timonium Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. any i Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Abohamer 7/2000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav 1 ☐ Yes 2 D 9 ☐ Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes XX No 3 ☐ Probably 4 Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; p 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ပ္ 1 🗋 Inpatient 2 🗆 ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 15 gv 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Aug 28, 2012 RWZO K125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNE LEWIS CRNP 6701 N charles St & 4105 Towson 31. Date filed (Month, Dav. Year 32. Registra 's Signa State 30 2012 AUG

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		ľ	For State Registrar		iviai yiai i		tificate of		anu iv		Reg. N	201	2, 27872
	Physicia		1. Decedent's Name (First, Midd Cornelia Vaartjes							2. Date of De Month 25	eath Da	<sup>ay</sup> 2012 Year	3. Time of Death 3:04 A. M
	Medic Examin		4a. Facility Name (if not institution	. •	per)		4b. City, Town	or Location		1109. 2.	40	c. County of Dea	ith
			3650 Emory Church		Z Acro (In such I	not hirthdow	Street If Under 1 Yea	r I If I Inde	r 24 Hrs.	8. Date of Bir		arford Co	
	Funeral Director		5. S2135e-607-116341 -214-38-4396 Usual Residence of Decedent	1 \( \text{M 2 \( \frac{\frac}{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac}}}}}{\frac{\fir}}}}}}{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac}}}}}}{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\fracc}\frac{\f{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\fracc}}}}}}{\frac{\f	7. Age (In yrs. Ia 100	Yrs.	Months Day		Min.	(Month, Da June 9,	rtn ay, Ye <i>ar)</i> 1913	2   HoL	rthplace (State or Foreign puntry) Land
	and show d at	rol	10a. State 10b. Count	y	10c. Cit	y, Town or Lo	cation		<u> </u>				10d. Inside City Limits
	Maryl 28a-f otifie	Director	_	rd County	Stree	et							1 ☐ Yes 2X No
	ith the	ralD	10e. Street and Number	Desd			10f. Zip Code					itizen of What C	ountry?
	eath w	Funeral	3650 Emory Church 11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. V	21154 Vas Decedent of Yes, specify Cu	Hispanic O	rigin? (Spe			od States	erican Indian.
920	e filed within 72 hours after death with the Maryland tal Hygiene.  So other than "natural", or items 23a or 28a-f show of other, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	2 XNo		f Yes, specify Cu			Rican, etc.)		Black, Whit Specify: Wh	te, etc.
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7	ithin 7 ene. r than	Com	Elementary/Secondary (0-12)	College (1-4	1 or 5+)	Home M	O NOT use retire	d)			Own	Home	
ام 2	illed w Il Hygi I other vent, 1	Be	17. Father's Name (First, Middle,	, Last)				18. Moti	her's Name	e (First, Middle,			
ylaı	should be file and Mental I is marked o raumatic eve	은	Cosse Schotarus					Gats	ke Wie	rsna			
		1	19a. Informant's Name/Relation Mrs. Agatha Shanna		c)	1	ng Address (Stree TOTY Chur					r Town, State, Z. 21154	ip Code)
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2X Cremation	n 3 Removal from §	State C	emetery, cren	sition (Name of natory or other p			Date	1	ocation - City or	
<u>#</u>	nit. Pagartmer artmer ortant injury		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service	(Specify)	Eva		ral Chape		08/27/			≆t Hill,	
Ba	permit Depar Impor any in		Lew 2 à	fem-		EV	ens Funer Vewport D	al Chap	el & C	remation	Serv	vices - Be	el Air
- F	hysician/	. 7	23a. Part 1. Enter the disease, on shock, or heart fallure. List Immediate Cause (Final disease or condition	t only one cause on each	used the death	h. Do not ente	er the mode of d	/ing, such as	s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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		ier	Sequentially list conditions, if any, leading to immediate	b	r as a consequ	uence of):							gla-s
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	ficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (o	r as a consequ	uence of):							
2.09	physic the b	edica		d									
9	certific inding   use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			1 =					23d. Date of de	elivery
Box	death ne atte ed for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		ant at time of c	aldeath 3 L death 5 L	Ectopic pregna Other (specify)	incy				Month	Day Year
	that the gned by the e detach	by P	Part II. Other significant condit		ath but not res	ulting in the u	nderlying cause	given in Par	t I.	23e. Did t	obacco	use contribute to	o the cause of death?
ds,	equires sen sig nould b	ted	rend 1 nsuff	icency						1 🗆	Yes 2	: ⊒-Mo 3 □ F	Probably 4 🗆 Unknown
Division of Vital Records,	s <b>ician:</b> The law requires certificate has been sign lirector, page 2 should be	Completed by Physician/Medical	dysola in							24a. Was auto perfo 1  Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
<u> </u>		Be (	25. Was case ref red to medica examiner?	l Hospital:				Place of De	ath (C <i>h</i> ec <i>k</i>				
<u> </u>	Physi this c aral dir	12	1 Yes 2 No	1 ☐ Ir	patient 2  finiury	ER/Outpatier	t 3 🗆 DOA			me 5 Resi		6 Other (Spec	cify)
o uoi	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate:	1 ☑Natural 5 ☐ Pend	ling (Month	, Day, Year)	injury	M 1	ork? Yes 2	No				
DIVIS	To the Hospital or Attend within 24 hours after death To the Funeral Director: Completely filled in by the the		4  Homicide deter	building	g, etc. (Specify	")	et, factory, offic			City or Tov	vn, State	e)	ural Route Number,
	e Hosp 24 ho Fune letely f	Medical	(Chack 2 Madical	ng Physician: To the best Examiner: On the basis ng Nurse Practitioner:	of examination	and/or invest	idation in my on	nion dooth o	and irrad at	the time date	and place	and due to the	cause(s) and manner stated
	To the withing To the comp		29b. Signature and title of certific	er		,отоиде,	29c. Lice	nse number	o and pid	23, 3, 12, 446 10	29d. Da	ate signed (Mont	th, Day, Year)
			30. Name and address of person	luy mo	·		D	31295			8	127/1	2_
			30. Name and address of person	n who completed cause	of death (Item	23a) (Type, P	rint) Zenwsod	- sue	_ 1	Backen	nere	mo	21206
	Stat Registra		31. Date filed (Month, Day, Year)	2012 37 Rec	gistrar's Signat	Lure -	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:140 M Beatrice Odessa Ward 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 7 / 1 3 / 1 9 2 3 Months Hours Min 89 **Director** 243-40-6473 N.C Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No N/A Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 635 E. 36th Street 21218 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Children Aide Mech-Rec. Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jonah Artis Fannie Newsome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Ward, Jr.-Son 635 36th St. Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/29/2012 OwingsMills. 21. Signature of Funeral Service Licens 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, rrany, leading to immediate cause. Enter Underlying Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and-trar Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Box 68760 nding parse as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Dav Pregnant at time of death signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/20/12 Stoch 875 1518732 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aviel 0 Bithung 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

AUG 3 (1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Nam (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 210 AM 2 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN BACTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 213-30-4187 Director 1 □ M 2 🛣 F 21 permit. Pege 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23e or 28e-f show emy injury or other treumatic event, the Medical Evaniner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDBALTIMORE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral CAMERON USA 21212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BIACK 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SEARS USTOMER SERVICE Be 17. Father's Name (First, Middle, Last) 's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) TONATHAN E. WELLS BACTIMORE, Md. 21212 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State BAUTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN GREENE FUNERAL SCKS Signature of Funeral Service Licensee AUTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or wa consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien and I for use es the burlel-transit Exami or Attending Physicien: The law requires thet the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year page 2 should be deteched the 9 Unknown 9 I Inknown signed by ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗆 Yes 2 🗆 No 3 💆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No s after death.

I Director: After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined To the Hospitel of within 24 hours a To the Funerel D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defice I Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 56 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Z Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ethel Month Day Marie 2:10 P M Watkins Medical August 28 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Gilchrist ocial Security Number Towson Jnder 1 Year Baltimore 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 219-18-3662 Months (Month, Day, Year) Hours Min. **Director** 1 M 2 KF Yrs 88 9/29/1923 Maryland or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 615 Chestnut Ave. # 452 21204 "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Mamied 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 X Divorced Completed Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Office Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Harry Ruby Μ. Harrison Naomi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sandra Trimmer / Daughter Thaxton Court Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖔 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) <u>Grace U.M. Ch. Cem.</u> 8/31/2012 Upperco, Maryland 21. Signature Function rvice Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ nset and Death Myocard aus Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 4 Nursing Home 5 Residence ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) WSF CO 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) arlun AUGUST 2912012 Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES M 6701 SI

State

Registrar

31. Date filed (Month, Day, Year) AUG 3 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JAMES** WOOTEN JR. AUGUST 20 Tea Α. 8:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST MARY S CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) IAN 23 193 9. Birthplace (State or Foreign 1 🏻 M 2 🗆 F Days 76 Hours Director 579-52-8082 Yrs 1936 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD PRINCE GEORGE'S CLINTON 1X Yes 2 □ No 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5103 ABILENE DRIVE 20735 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 XWidowed 4 ☐ Divorced Specify. BLACK is marked other than "natural aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12th MEDIA MANAGER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 of Health and Ments fitem 27 is marked r other traumatic e JAMES A. WOOTEN SR. MARTHA С. WALSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN BROCK 3220 SWANN ED #302 SUITLAND, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY 8/28/2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. N aphne 7474 LANDOVER RD. HYATTSVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause — ach line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death disease or condition yres Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediato cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached the Unknown P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No DIABETES MELLITUS this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, Division of Vital To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the fi

and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN CAFFERTY MD 31. Date filed (Month, Day, Year) Registrar

29a. Certifie (Check

only one

29449 CHARLOTTE HALL RD CHARLOTTE HALL, MARYLAND 20622

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

H37-228 MD

29d. Date signed (Month, Day, Year)

24

2012

sician/	1 State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of L	2. Date of De	
edical	MILDRED WILHELM		AUGÜST	28,2012 Year 5:21 A. N
miner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	4c. County of Death
eral	OAK CREST VILLAGE  5. Social Security Number 6. Sex 7. Age (In yrs.		VII.I.E If Under 24 Hrs. 8. Date of Bir	th 9. Birthplace (State or Foreign
tor	219-16-6752   1   M 2   XF   89   Usual Residence of Decedent	Yrs. Months Days		16,1923 MARYLAND
i j		ity, Town or Location		10d. Inside City Limits
irec	MD. BALTO.	PARKVILLE		1 ☐ Yes 2 <b>X</b> No
once.  To Be Completed by Funeral Director	10e. Street and Number  8800 WALTHER BLVD.	10f. Zip Code <b>21234</b>		10g. Citizen of What Country?  USA
E E	11. Marital Status 12. Was Decedent Ever in U	.S. 13. Was Decedent of His	spanic Origin? (Specify Yes or No-	14. Race - American Indian,
db	1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Vegr or Dates		n, Mexican, Puerto Rican, etc.)  Specify:	Black, White, etc.
Completed	3 Lawidowed 4 Li Divorced Year or Dates.  15. Decedent's Education	16a. Decedent's Usual Occupa		Specify: WHITE
를	(Specify only highest grade completed)	(Give kind of work done de life. DO NOT use retired)	uring most of working	16b. Kind of Business Industry
	8TH	CLERK		J.S. POSTAL SERVICE
To Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle,	Maiden Surname)
	CHARLES BROCKMEYER		MARY HUBER	
	19a. Informant's Name/Relationship (Type, Print)  JANICE RICHARDSON  DTR.	19b. Mailing Address (Street at 14 RIDGECLIF)	nd Number or Rural Route Number	
	20a. Method of Disposition 20b.	Place of Disposition (Name of	Date	VILLE, MD. 21087  20c. Location - City or Town, State
<u> </u>	The state of the s	cemetery, crematory or other place  JOSEPH CEMETER		
jo jo	21. Signature of Juneral Service License	22. Name and Address		FULLERTON, MD. FUNERAL HOME, INC.
i gi	Juninere	9705 BEL	AIR ROAD NOTTIN	NGHAM, MD. 21236
cal Examiner	23a Part 1 Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	, con as said as a respiratory an	Approximate Interval Between Onset and Death
Medical Examiner	Cause (Disease or in) injury that initiated events resulting in death) Last  C	uence of):		
Physician/Medi	1  Yes 2 No 4 Pregnant at time of 0 9 Unknown	al death 3		23d. Date of delivery Month Day Year
eted by	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause give	1 □ Y	
completed by Physi			24a. Was a autop: perfor	sy prior to completion of cause of
Be	25. Was case referred to medical examiner?	26. Plac	ce of Death (Check only one)	ZA NO TES ZENO
၉	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Others	4 Nursing Home 5 Reside	ence 6 Other (Specify)
cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			ow injury occurred
	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specify		City or Towr	
al Certificate:			late and place, and due to the cau	se(s) and manner as stated.
Medical Certifi	29a. Certifier (Check conly one)  1 Certifying Physician: To the best of my knowl Medical Examiner: On the basis of examination only one)  1 Certifying Nurse Practioner: To the best of my knowl	n and/or investigation, in my opinion, y knowledge, death occurred at the t	ime, date and place, and due to the	d place, and due to the cause(s) and manner stated cause(s) and manner as stated.
Medical	only one) 3 Certifying Nurse Practioner: To the best of my	n and/or investigation, in my opinion, y knowledge, death occurred at the t	ime, date and place, and due to the	d place, and due to the cause(s) and manner stated cause(s) and manner as stated.  9d. Date signed (Month, Day, Year)  8/28/2012
	only one) 3 Certifying Nurse Practioner: To the best of my	n and/or investigation, in my opinion, y knowledge, death occurred at the to a second	ime, date and place, and due to the	cause(s) and manner as stated.  19d. Pate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26<sup>Day</sup> Month 08 2012 James J. Woods, Jr. 11:22 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Bel Air Harford Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign MD Country) **Funeral** 1 24 M 2 D F Days 0470471936 212-32-6102 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a, State 10b. County 10c. City, Town or Location Director MD Harford Edgewood 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21040 1846 Emily Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' Black, White, etc. o. þ 1 Never Married 2 X Married Yes, Giv 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Director of Engineering Hospital traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret McCormick James J. Woods, Sr. 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1846 Emily Drive, Edgewood, MD 21040 Linda Woods - Spouse Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) 08/28/2012 Glen Burnie, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Party. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List on your cause meach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physiciar Be Completed by Physician/Medical 68760 or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s perform 2 No Yes 2-No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 🗌 No Certificate: To 1 ☐ Inpatient 2 → ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0036487 ress of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chescopeake Dr ucmo Bentman Belair, md 21014

State Registrar

118003384

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANOR m NURS-1-6mi 111115 . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 6. Sex 8. Date of Birth (Month, Day, 1 □ M 2 🖫 F Months Days Min. Director Usual Residence of Decedent 10c. City, Town or Location 1∩a State 10b County 10d. Inside City Limits items 23a or 28a-f show Department of Health and Mental Hygiene. Important: "or Items 23a or 28a-f short proportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f short proportant: If item 27 is marked other than any injury or other traumatic event, the Medical Evantment must be notified at 1 ☐ Yes 2 ▼No by Funeral Director BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number MILTORD mill 4204 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 V No BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 14 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Konald 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Bernál 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licepses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Rementia To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Falluno mnne Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 ☐ Probably 4 ☐ Unknown 2 🗌 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 🗆 Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 □Yes 2 □No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 072536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUMIT BHUTANI 821N RMION SWELL SWIY 308

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27880 Certificate of Death 2 Date of Death 3. Time of Death Physician/ Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRIMIE 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day Min Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PHINCE GEORGE 1 Yes 2 □ No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) NATIONAL Elementary/Seconday (0-12) OLOGI NSTITUTE OF HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WATERS 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final DRUSTATE Physician CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗆 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this c completed filled in by the funeral dire

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of persón who completed cause of death (Item 23a) (Type, Print) 2805 SMITH

MITEMEllule Russ HIOY BOWIE MD 207/6

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Mary Emily Young 23.40 M 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Harford County **Examiner** Bel Air Upper Chesapeake Medical Center Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 3314C Days Hours Min 218-26-3686 Director 1 □ M 2 🔀 F 83 12/22/1928 Maryland Usual Residence of Deceden 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Maryland Harrford County Street 10e. Street and Numbe 10f. Zip Code 0 10g. Citizen of What Country? 23a Funeral United States 4229 Rocks Road 21154 items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 þ 1 Never Married 2 X Married ☐ Yes 2 X No Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 9 other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of ည Mary Emily Miller Ralph Schaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1045 Doyle Road. Street, Maryland 21154 Mr. Alan Young (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 
Burial 2 
Cremation 3 
Removal from State cemetery, crematory or other place) Forest Hill, Maryland 08/29/2012 4 Donation 5 Other (Specify) Evans Funeral Chapel 22. Name and Address of Facility & Cremation Services - Bel Air 21. Signature of Funeral Service Licenses B Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner 20 Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live Fetal death in the past 12 month Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work within 24 hours after deaun.

To the Funeral Director: Aft 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Je Tang flonth, Day Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Marylan				Mental Hy	giene	0 07000
		ď	Regîstrar  1. Decedent's Name (First, Middle, Las	f)	Cer	tificate of L	Death	1	Reg. No. 2	2 27882
Physi	cian/	/		Zajdel				2. Date of De Month AUA	Day Year	3. Time of Death 2 /2 / 02 pM
	nine		4a. Facility Name (if not institution, give				Location of Death		4c. County of De	
			Mercy Medical  5. Social Security Number 6. Se	Centr 7. Age (In yrs. Ia	et hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th las	irthplace (State or Foreign
Funer Direct	_			□ M 2 🖽 F 6		Months Days	Hours Min.	(Month, Da		ountry) MD
how at	٦,	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation		Δ.	•	10d. Inside City Limits
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Euroral Director		MD		altim					1 ॲYes 2 ☐ No
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ath wit ms 23 must	Ì		508 South Ro	binson Stree  12. Was Decedent Ever in U.S		212: Vas Decedent of H		acifu Vac or No	USA	
6 ter dea or ite miner	7		1 🔀 Never Married 2 🗌 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	l:	Yes, specify Cuba	ın, Mexican, Puert	Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
003 ours af tural", al Exa	4	ופח	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		Yes 2 X No			3,555,7	hite
215- 172 ho an "na Medio	Completed		15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	lent's Usual Occup kind of work done o D NOT use retired)	ation during most of wor	king	16b. Kind of Busines	s Industry
212   withir   withir   ygiene   ygiene   ner th	2		Elementary/Seconday (0-12) 12th	College (1-4 or 5+)		ir Styl	ist		Kosmio	Scissors
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	To Bo		17. Father's Name (First, Middle, Last)  Edwin S. Zaj	del				ne (First, Middle, red Rot	Maiden Surname) E <b>h</b>	
Aaryland should be file and Mental P is marked o raumatic eve		1	19a. Informant's Name/Relationship (Ty						r, City or Town, State, 2	Zip Code)
e, N and 2 Health em 27 ther tr			Edwin J. Zajde			Shell Shell Sition (Name of	Cove J			Town Chata
Page 1 ment of ant: If it			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	emetery, cren	natory or other place Cremato	e) orv 8/	Date 27/12	20c. Location - City of Baltim	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe	nce.	1	21. Signature of Fureral Service Licens			. Name and Addres	ss of Facility	300 Mag	ce Ave. B	alto. MD
	OI	+	23a. Part 1. Enter the disease, Groomp	lications that caused the death	Do not ente				ne of Ess	ex 21221  Approximate
Physicis	est.	1	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
Medic Examin	al		disease or condition resulting in death)	a. Signet ring  Due to (or as a consort	ence of):	undare	Marria	VOLIFI IN	01030013	2 monms
LAMITIN		,	Seque tially list conditions, if any, leading to immediate	Due to (or as a consequ	ence off:					
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be executed sician and burial-transit			that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
0 > 0	edici			d						
certifical	M/me	1   2	SD. Was decedent pregnant	23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta		Estania prognana	24		23d. Date of d	elivery
ords, P.O. Box 6876 requires that the death certificat been signed by the attending ph should be detached for use as th	Physician/Medical		in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of d		Other (specify)	· y		Month	Day Year
Records, P.O. I The law requires that the ate has been signed by the page 2 should be detache	by Ph		Part II. Other significant conditions co	ntributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds, quires en sig								1 🗆	Yes 2 No 3 🗆	Probably 4 🗆 Unknown
Division of Vital Records, tal or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was		utopsy findings available completion of cause of
Vital Reco sician: The law i certificate has b irector, page 2 si			25. Was case referred to medical			26 Die	ace of Death (Che	1 🗆 Yes		es 2 🗆 No
Vital vysician: vysician: director,	To Be		examiner? 1  Yes 2 No	lospital: Inpatient 2 🗆	ER/Outpatien	1	ar-		dence 6  Other (Spe	ecify)
Sion of Vital Attending Physician: ar death. ector: Affer this certific by the funeral director,			27. Manner of Death  Natural 5 Pending		28b. Time of injury	28c. Injury work	?	28d. Describe h	now injury occurred	
SIOT Attend r death ctor: /	Certificate:		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos	me, farm, stre		Yes 2 No	28f. Location (S	Street and Number or F	ural Route Number
DIVI			4 - Homicide determined	building, etc. (Specify)				City or Tow		
DIVISION  To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fu	ledical		(Check 2 L Medical Examin	ician: To the best of my knowledger: On the basis of examination	and/or invest	igation, in my opinio	n, death occurred	at the time, date a	ind place, and due to the	e cause(s) and manner stated.
To the within To the Compl	Σ	:  -	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of my		20e Licopeo	numbor		00d Data siamed (\$46.5	th Day Yearl
			1 the			1619	12336	57	Aug 24	2012
V		3	30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, P	rint)	121 201	St Da	IDI Baltus	ne 110 2/2 22
s	tate	3	d D. L. Cl. M44 // D. M. L.	ompleted cause of death (Item  Mercy  32. Registrar's Sinate	ure are	ce cens	KI NI	JI PAU	ITI OUIDME	JULY LIVE
Regis	strar		AUG 3 0 2012	Kendy L.	7					

DHMH 17 Rev 7/2009

State

Registrar

AUG 3 0 2012

12-05887 Ishmael Boakye Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hmael Boakye	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No. 20   2 278									
Physician ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	Time of Death 0036 hrs						
	4a. Facility Name (if not institution, give street and number) 10904 Woodlawn Blvd	4b. City, Town, or Location of Death Upper Marlboro								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthpla	ce (State or hana						
Baltimore, MD 21215-0036  S S S S S S S S S S S S S S S S S S S	Usual Residence of Decedent  10a. State 10b. County  MD Prince George's Rivero  10e. Street and Number  6813 Riverdale Road # H-7  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  17. Father's Name (First, Middle, Last)  Edward K. Manu  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin  Adwoa Eshun/Sister  20a. Method of Disposition 1 Namidal 2 Cremation 3 Removal from State 4 Donation 5 Other, Specify: 21. Signeture of Funeral Streen State of Gate of Gate of Gailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,	10/30/1984 Foreign Counce  10g. Citizen of What Country?  Ghana  Decify Yes or No- Rican, etc.)  14. Race - American White, etc.  Specify: Bla  Work done red)  Retail  (First, Middle, Maiden Surname)  ria Foriwa  Rural Route Number, City or Town, State, Zip  Date  20c. Location = City or Town  7/2012 Silver Sp  I FUNERAL SERVICE  Lvd. Silver Spring respiratory arrest, shock, or heart  A	hana I Inside City Limits  X Yes 2 No  Indian, Black,  Ck  Stry  Code 904  Md  T state  ring, Md							
b.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   tal death 3 Ectopic pregna her (Specify)  Inderlying cause given in Part I.	ncy 23d. Date of delivery  Month Day  23e. Did tobacco use contribute to the c	Year ause of death?							
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed be completely filled in by the funeral director, page 2 should be detac.  Medical Certification: To Be Completed by 18		26.Place of Death (Check of 3 DOA Other Mursing place)  28c. Injury at Work?  1 Yes 2 No Notet, factory, office building, etc.	autopsy performed?  1  Yes 2 No 1  Yes  28d. Describe how injury occurred  Subject was shot  28f. Location (Street and Number or Rural R or Town, State) 10904 Woodlawn Blvd, Upper Marlborodue to the cause(s) and manner as stated.	y findings available letion of cause of 2 No No No ne						
3	29b. Signature and title of certifier  August Pyrithall, MD  30. Name and address of person who completed cause of death (Item 23a)	29c. License number O.C.M.E.	29d. Date signed (Month, I August 7, 2012	Day, Year)						
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature	W. Baltimore Street, Baltin	1101E, MID 21223							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enny Lu Friend		1- For State	ate of Maryla		artment of rtificate of		and N	Mental	Hygi		g. No.	201	2	27885
Physicia cal Exami	an/	Registrar  1. Decedent's Name (First, Middent's Name (First, Middent's Name)	le,Last)Penny nd Bathum	Friend	Bathum					Date of Death Month Jugust 19,	Day Y 2012	ear	3 Time 0	
		4a. Facility Name (if not institution Garrett Memorial Hos	pital			b. City, Town Oakland					Garret			
Funeral Director		5. Social Security Number 214-62-2523	6. Sex	7. Age (In yrs.	last birthday)  58 Yrs.	If Under 1	$\overline{}$	f Under 24 Hours	Min.	Sept.	29, 19	Foreig 53 Coi	npiace (S n untry) Ma	aryland
aryland 8a-f show any at once.	5	Usual Residence of Decedent  10a. State 10b. County  WA Kin	g	1	, Town or Location	on								de City Limits
ith the Maryland 23a or 28a-f sho notified at once.	al Director	10e. Street and Number 46905 283rd S 11. Marital Status		cedent Ever in U	10 13 18/2	10f. Zip Cod 98022 s Decedent o	2	nic Origin?	/ Specifi		g. Citizen of \USA	What Cour		n. Black
after death wi al", or items	by Funeral	1 Never Married 2 X N 3 Widowed 4 Di	larried Armed F  1 Yes  Vorced If Yes, Give Ye  or Dates:	forces? 2 X No	1f Ye	es, specify Co	uban, M No s,	exican, Pu pecify:	ierto Rica	an, etc.)	Wf Specify	nite, etc.	White	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examinger must be notified at once	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)		t's Usual Occ ost of working 1 Work	life. DO	) NOT use	e retired)			n Chi		Welfare
21215-0036 Nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be Cor	17. Father's Name (First, Middle Amos T. Frien  19a. Informant's Name/Relation	d		19h Mailine	Address (9	В	ernad	dine	Devin	laiden Surnar E ber, City or To		Zin Cod	e)
e, MD 2 1 and 2 shoul Health and M item 27 is m	ř	Richard W. Ba	thum/Husb	20b.	Place of Dispos	ition (Name of	S.	E., E	Enumo Da	claw,	WA 98 20c. Locatio	002 n - City or	Town, St	ate
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 Burial 2 X Crematic 4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee	CC CC	ountry S	ide Cr	ress of	Facility 1	<del>đewin</del> a	an Fun	2012 Da eral H Grants	omes.	, P. P	4.
Physician /Medical Examiner	пег	23a. Part ( Enter the disease, o failure List only one cause Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Asphyx Due to (or as b. Neck 1 Due to (or as	a consequence	n. Do not enter the of):  complica	ne mode of d	ing, suc	ch as cardi	iac or res	spiratory arre	est, shock, or		Approx	ximate Interval en Onset and Death
be executed cian and ural - transit	dical Examiner													
Box 68760, e deuth certificate be er the attending physician the for use as the burial control of the burial control of the co	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  Ur	23c, If yes 1 Live 4 Preg	outcome of pre- birth nant at time of d	gnancy 2 Fe	tal death	3 🗌	Ectopic pr			23d. Date Month		Day	Year
P.O. es that the igned by the detache	á	Part II. Other significant cond	tions contributing	to death but not	resulting in the u	inderlying ca	use give	en in Part I			bacco use co 2 ✓ No	3 Pro	bably 4	
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Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al Certification	3 Suicide 6 Co	28e. Pla 28e. Pla (Specify	Rese	nome, farm, street rvoir edge, death occur	rred at the tin	ne, date	and place	Re	or Town, S SETVO	tate) Youg ir Gat e(s) and man	chiog rett ner as sta	heny Coui	River River nty,MD.
To the within: To the complex	Medical	29b/Signature and title of certi	aminer: On the basis and manner ier	s of examination stated.	and/or investiga	29c. L	icense n	ıumber	rred at th	e time, date	29d. Date s August 2	igned (Mo	onth, Day,	
	0	30. Name and address of person Laron Locke MD.	on who completed ca Assistant Medic		900 W. Ba		treet,	Baltimo	re, MD	21223				
S Regis	tate			Registrar's Signa	4 . 4									

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 27886 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Andeara Burch Janine 12:07P.M 2012 20 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Waldorf 12520 Chipmunk Pl. 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 216-96-3593 1 M 2 X F 45 04/14/1967 Usual Residence of Decedent Pennsylvania 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No MD Charles Waldorf 10e. Street and Numbe 5 10f. Zip Code 10a. Citizen of What Country? pe 23a Funeral must United States 12520 Chipmunk 20601 Ρl 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Armed Forces or 1 Never Married 2 Married by Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give "natural", Completed 3 Divorced 4 Divorced Year or Dates White r than "natur the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Rusiness/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. the U.S. Census Bureau Program Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Betty Jean Stoll John Andeara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Michael L. Burch/Spouse 12520 Chipmunk Pl., Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. ō 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Trinity Mem. Gds. 08/25/12 Waldorf, Maryland 22. Name and Address of Facility Raymond Funeral Svc., P.A. Sign ature of Funeral Service Licent 01517 5635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between pulminuny disense Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner ort bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or Injury that initiated events resulting in death) Last endo metriosi tran and Due to (or as a consequence of) as the burialattending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires 1 Yes No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perfore 1 Yes 2 No Yes /2 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes ② No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) mo 000620

State Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vashinatun

Rel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08 Month 7:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death City, Town, or Location of Death Hospice of Queen annes entreville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2 😿 F 12/27/1942 Director <u>6</u>9 212-40-9577 "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
 Barti. Hi few 27.5 is marked other than "natural", or items 23a or 28a-f shov lury or other traumatic event, the Medical Examiner must be notified at lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDOueen Annes Stevensville 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Hoaney Lane 21666 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Glass Manufacturing Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alfred Daniel Hoaney Hazel Lee Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Austin/Son 107 Hoaney Lane Stevensville, MD 21666 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 200. Place of Disposition (Varies of cemetery, crematory or other place)
Direct Crematory, 8/13/2012 Dover, DE 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lices Bennie Smith FuneralHome T Easton, MD 21601 STDover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBLOVASIVUM AccisENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENS, OF Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and Il-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician s should be detached for use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Year 1 Yes 2/1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHEVMPIO ALTHU TIS 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t director, page 2 s autopsy performe death? Yes 2 No 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 1 🗌 Yes Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) HoSfice this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of certer 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital
within 24 hours a
To the Funeral I Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D41339 3 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 125 SHAZNAY DRIVE QUENSTOJA

State

Registrar

31. Date filed (Month, Day, Year)

AHG

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 AUG. Julia 3:50  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and nur Examiner 4b. City, Town, or Location of Death 4c. County of Death 25484 CROMWELL CLARK ROAD CHESTERTOWN KENT Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F MAY 20, 1919 **Director** 219-44-1961 93 MARYLAND 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD KENT CHESTERTOWN 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25484 CROMWELL CLARK ROAD 21620 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOHN THOMAS HARRINGTON MADGE COLLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 25089 MARY MORRIS ROAD, CHESTERTOWN, MD 21620 THOMAS CLARK/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State AUG. Date 1 X Burial 2 Cremation 3 Removal from State ST. JAMES CEMETERY 4 Donation 5 Other (Specify) WORTON, MARYLAND 2012 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 . Mart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph sician/ CEREBROVASCULAR ACCIDEN disease or condition resulting in death) an Medical Due to (or as a consequence of Examiner Sequentially list conditions. Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Dav g Unknown g Unknown P.O. I signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HYPERTENSIVE CARDIOVASCULAR DISEASE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 X Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 DO041587 8-2-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MC 122 SPEER ROAD, CHESTERTOWN, MD 21620 HELEN A. NOBLE, M.D. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08 Month Physician/ 2012 10:13 AM Howard Samuel Case Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Birthpic. Country) N<u>J</u> **Funeral** 1 🛛 M 2 🗆 F Davs Hours Min. Months 09/18/194. Director 157-32-2231 70 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Funeral Director MD Westminster 28a-f Carroll 1 🗆 Yes 2 🛣 No 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1201 Pinch Valley Rd 21158 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black White etc 0 ģ 1 Never Married 2 X Married 2 X No ☐ Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) McDaniel College Professor of Health and Mental Hygie. If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Libby Moskin Howard N. Case 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip. Code). 1201 Pinch Valley Rd., Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) Susan Case/wife nt of Health a t: If item 27 i vor other tra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or Carroll Cremation 08/23/2012 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Prints Funeral Home and Chapel, PA Signature of Funeral Service Lice de 16 Westminster, MD 21157 412 Washington Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus — each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) **Examiner** E Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury o (or as a consequence of): HEROW TRANSPLANT Examil transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last ng physician al as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Day Month Year 2 No the a g Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate Yes 2 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one, Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending Natural after death. 2 🗌 No Investigation Could not be Accident the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

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within 2

(Check

only one

Certifying Nurse P

npleted cause of death (Item 23a) (Type, Print)

actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month DOROTHY BAY COOKSEY 1:20 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata Charles Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) Months Davs Hours Min (Month, Day, Year) Director 219-18-0697 1 □ M 2X□XF 88 Yrs MAY 22,1924 MARYLAND 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified CHARLES LA PLATA MD 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U. S. A. 20646 10584 CHARLES STREET 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō þ 1 Never Married 2 Married Black, White, etc. Dorothy M Maryland 21215-0036 1 Yes If Yes, Give 1 Yes 2 No Specify "natural", ₩Widowed 4 Divorced Completed Specify: WHITE Year or Dates. 1946 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I BANK OF SO. MD BANK TELLER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PAULINE WILSON JOHN W. BAY 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10382 CHARLES STREET LA PLATA, MD 20646 NANCY ALMOND / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 08/ 20c. Location - City or Town, State 1 September 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 24,2012 DENTSVILLE, MD DENTSVILLE METH.CEM. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P. A. M00641 PLATA, MD 20646 5635 WASHINGTON AVE., LA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Belatera DRU Monia disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Vear 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 XInpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69566

State Registrar Corrett Avenue, La Plata,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHEIMDS

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 23 Day 201<sup>Year</sup> Lillian Aug. 5:45 Stutz Craig AM4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17050 Broadfording Road Hagerstown Washington Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Director 220-10-3062 1 M 2 K F 92 08/26/1919 D.C. show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Washington 1 Yes 2X No Hagerstown 10e, Street and Number 10f, Zip Code 'n 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be by Funeral Page 1 and 2 should be filed within 72 hours after death with U.S.A. 21740 17050 Broadfording Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Paving/Construction Corporate Secretary event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever ဂ္ Henry Ernest Tina Marquiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17046 Broadfording Rd. Hagerstown, Maryland 21740 Ralph D. Craig / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If itel
any injury or oth 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Rest Haven Cemetery 108/27/2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compil at ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ONGESTIVE MONTHS Medical Due to (or as a consequence of): Examiner ORONARY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit HYPERTONS, ON that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 nse 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTA CERESCONASCULAR DIGASE 2 No 3 Probably 4 Unknown 1 🗌 Yes CARCINOMA, URINARY TRACT INFECTION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy performed' death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital: Other: No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records,

within 24 hours a 0

Registrar

Medical

29a, Certifier

31. Date filed (Month, Day, Year AUG 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SUITE

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 18, 8/1/12, RM, Kent State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0625A M orge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death nester Liver Cent Levi 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1 M 2 □ F **Director** 220-03-0723 MD OS 29 28a-f show ms 23a or 28a-f sho must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Chestertown 1 Yes 2 No Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 240 College Avenue 21620 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian o. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give 1 0 Baltimore, Maryland 21215-0036 Year or Dates. 1942 1 Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Black other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) Rosie Goldsboro 17. Father's Name (First, Middle, Last) if Health and Mental Hitem 27 is marked ot other traumatic ever ၉ George Derry Susie Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Patricia Watts/Daughter 1233 E. Belvedere Ave. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o Department of Emmanuel U.M. Church 8/4/12 1X Burial 2 Cremation 3 Removal from State Chestertown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home Signature of Funeral Service Language High ST Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ hyper cappia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or injury multi attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by heart 1 Yes 2 No 3 Probably 4 M Unknown (ibrill dron with rapid verticals 24b. Were autopsy findings available prior to completion of cause of autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Plecial CECUSION 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) ည 1 Yes 2 Yo Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0073885 GUNZalo L.C. 07/25/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+. Chestetown, MD 2/620 Luizaga Coca 100 Brown 31. Date filed (Month, Day Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Physician/ Medical Examiner **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Be Completed by Funeral Director

Registrar			Certificat	e of D	eath			Reg. N	·2 N	12	278	3 Q L
1. Decedent's Name (First, Middle, La	st)		2. Date of I					ath	<del></del>	1 6	3. Time of	Death
John Stephen	Fitzgerald	l					August	$11^{D}$	ay 20	) řear	3:00	ам
4a. Facility Name (if not institution, give	e street and number)		4b. City,		Location of			4	c. County	of Death		
423 Branch Drive				Silv	er Sp	ring	3		Мо	ntgor	nery	
5. Social Security Number 6. S		e (In yrs. last birthd	lay) If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	h /, Year)		9. Birthp Coun	place (State or	r Foreign
216-58-7316 Usual Residence of Decedent	M 2 □ F 61	L Yr	s.	1			July 11				ington	
10a. State 10b. County		10c. City, Town o	r Location							1	I0d. Inside Cit	y Limits
MD Mont	gomery	Silve	er Spri	ne							1 🗌 Yes	2XX No
10e. Street and Number	8		10f. Zij					10g. C	Citizen of	What Cour	ntry?	
423 Branch Driv	e			2090	1			Ţ	JSA			
11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece	dent of Hi	spanic One	gin? (Spe	ecify Yes or No- Rican, etc.)				an Indian,	
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No	1 🗆 Yes				riidari, etc.j		Blac	white, white, white, white	etc. <del>2</del>	
3 Widowed 4 Divorced	Year or Dates.					_			Specily			
15. Decedent's E (Specify only highest gi		1 (0	ecedent's Usu Give kind of wo	rk done a	ation <i>luring m</i> ost	of work	ing	16b.	Kind of B	usiness/In	dustry	
Elementary/Secondary (0-12)	College (1-4 or 5	·+) ]	fe. DO NOT us ome Ren		er			Co	netr	uctio	າກ	
17. Father's Name (First, Middle, Last)		111	ome Ren	Iouci		er's Nam	e (First, Middle,				<b>711</b>	
Frederick Michae		ld, Sr.					Frances					
19a. Informant's Name/Relationship (	Type, Print)	19b. N	Mailing Addres	s (Street a	and Numbe	er or Rura	al Route Number	r, City o	or Town, S	State, Zip (	Code)	
Mary Ann Fitzgera	ld/Wife	423	Branch	Dri	ve, S	ilve	er Sprin	ıg,N	ID 20	901		
20a. Method of Disposition	7	20b. Place of D	Disposition (National Communications)		a)	Δ110	Date 14,	20c.	Location	- City or To	own, State	
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Gate of				Y 2	012	S11	ver	Spri	ng, MD	
21. Signature of Funeral Service Licen	see		Franci	nd Addres	s of Facilit	yins	Funeral	Нс	me I	nc.	_	
Velent (	)/ Jp-		500 Un	iver	sity	B <sub>1</sub> vc	1. W., S	Silv	er S	pring	g, MD 2	20901
23a. Part 1. Enter the disease, or com shock, or heart failure. List only			enter the mod	le of dyin	g, such as	cardiac o	or respiratory arr	rest,			Approximate Interval Bety	ween
Immediate Cause (Final disease or condition		11 Cell 1	Lung Ca	ncer							15 mos	eath
resulting in death)	Due to (or as	a consequence of):	:									
Sequentially list conditions	Chronic	Lung Dia	sease									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	:									
Cause (Disease or injury that initiated events	c											
resulting in death) Last	Due to (or as	a consequence of):	:									
•	d									-		
IF FEMALE:	23c. If yes, outcome	of pregnancy										
23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic 5 Other (s		у					ite of deliver	1.00	/ear
1 Yes 2 No	9 Unknown	t tille of death	3 LI Other (s	Decity) _							,	
Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause giv	en in Part	l.	23e. Did to	bacco	use cont	ribute to th	he cause of de	eath?
Chronic Artery D	isease, Me	lanoma					1 🗆 '	Yes	2 🗆 No	3♣ Pro	bably 4 🗆 t	Unknown
							24a. Was	an	24b.	Were auto	psy findings a	available
							autor perfo	osy rmed?		death?	psy findings a mpletion of ca	ause of
25. Was case referred to medical				00.5			1 🗆 Yes	2 🔀 1	No	1 🗌 Yes	2 🗆 No	
examiner?  1  Yes 2  No	Hospital:			Oth	)r:		k only one)					
1 100 2 1110	I 1 ∐ Inpati	ent 2 🗆 ER/Outp	oatient 3 ∟ D	UA	4 ∐ Ni	ursina Ha	me 5 A Resid	ence	6 ☐ Oth	er (Specify	/)	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burn the tental process. Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

၉

Examiner

				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
. Was case referred to medical			26. Place of Death (Che	ck only one)	_
examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐	DOA Other: 4 I Nursing H	lome 5 🖾 Residence 6	Other (Specify)
<ul> <li>Manner of Death</li> <li>1 A Natural 5 Pending</li> <li>2 Accident Investigation</li> </ul>		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci		ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
9a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, death occurred	at the time, date and place,	and due to the cause(s) an	d manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D35996

#400

August 13, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2730 University Blvd. W., Wheaton, MD 20902 Linda M. Burrell, MD

AUG 14 2012

31. Date filed (Month, Day, Year) State Registrar

Medical

72. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25 per me, g932 10-23-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. 2<u>012</u> Physician/ AUGUST 13. 10:15 PM DOROTHY PLATT YOUKEY GRUEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN CHESTER RIVER MANOR Funeral Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 XF Hours 12/21/1920 WISCONSIN Director 308-14-4477 91 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filled within 72 hours after death with the Manyland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shw 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MARYLAND KENT CHESTERTOWN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral UNITED STATES 10718 TILDEN LANE 21620 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Yes Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 X No Specify: 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 4 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ NEIL E. PLATT MARTHA HERMAN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra MARTI HAWKINS / DAUGHTER 10718 TILDEN LANE CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 08/14/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUENERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ INTRACEREBRAL disease or condition resulting in death) HEMORRHAGE nears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of, CERTIFICATION APPROVED BY MEDICAL EXAMI Exami and Due to (or as a consequence of): physician s the burial Physician/Medical certificate be Box 68760 as guipu IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ atten for u in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 No Yes 2 No ital or Attendir g Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 X Yes 2 X Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I eral Director: Af er this filled in by the fureral di 27 Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp (Check Certifying Nurse Practioner: To the best of my

Registrar

State

29b. Signature and tifle of certifier

of death (Item 23a) (Type, Print)

peer Road

D004158

Chestertown MD

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ LOWELL RAY GARRETT 2:25PM August 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Cntr Bel Air 8. Date of Birth (Month, Day, Year) 6/19/1936 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 215-34-7330 **Director** 1 □**X**M 2 □ F 76 Maryland Usual Residence of Dec ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Darlington 1 🗆 Yes 2 🏅 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3918 Conowingo Road 21034 Funeral ral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 1 Yes 2 No Specify White item 27 is marked other than "natural", other traumatic event, the Medical Exal Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. Public School Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Owner/Operator Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Tomlinson Ray W. Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Leftwich/Wife 3918 Conowingo Road, Darlington, MD 21034 t: If item 27 i and 2 s Health Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Vernon Cem. 20c. Location - City or Town, State to permit. Page 1
Department of
Important: If it
any injury or o 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/23/2012 Whiteford, MD 21. Signature of Fundal Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA rober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nh Death Immediate Cause (Final Physician/ disease or condition resulting in death) REL 7 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last physician Medical 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No the Unknown P.O. been signed by ti should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s has autopsy performe death? this certificate 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Director: After (Month, Day, Year) Hospital or Attending | Natural | | Accident 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 🗌 3 🔲 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) con August 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Thompson M.D., 500 Upper Chesapeake Dr., Bel Air , MD 21014

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3 0 2012

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Month Betty Victoria Gibbons 10:30AM A110 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick 2024 Jefferson Pike Knoxville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days (Month, Day, Year) 219-12-2459 91 Director 1 □ M 💥 F May 26, 1921 Maryland Usual Residence of Decedent | Hygiene. other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Maryland Frederick Knoxville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2024 Jefferson Pike 21758 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2¾☐ No Specify. Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ε. Elmer Michael Helen Grace Stauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millard Gibbons, Jr , Son 156 Monarch Ct, Martinsburg, West Virginia 25403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 22, 2012 Mt Olivet Cemetery 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licerse 22. Name and Address of Facility & Basford P.A. Funeral Home Church St. Frederick, Maryland Keeney 06 East Reeney & Basford P.A. Fune MOO706 106 East Church St, Frederic Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Demen Ha disease or condition Dars Medical resulting in death) Due to (or as a consequence of): Examiner erebro vascular 1eav Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths?

1 Yes 2 No
9 Unknown Day Pregnant at time of death ed by the a detached t g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by tate has been signe page 2 should be distast 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronicobshichus 24a. Was an certificate has autopsy within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ۵ 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 217/6

Registrar

DHMH 17 Rev 06-201

State

Maryland 21215-0036

Box 68760

Records,

of Vital

Division

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mark William Guethler State of Maryland / Department of Health and Mental Hygiene 2012 27898 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Medical Examiner** 0521 hrs August 22, 2012 Mark William Guethler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Rising Sun 212 Post Road Cecil If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs, last birthday) Months Days Min. Hours Director Country) MD 1 X M 2 F 11/21/1957 Yrs 217-64-0909 54 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No or 28a-f shov Rising Sun Cecil with the Maryland Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 212 Post Road 21911 United States items 23a 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item Armed Forces? White etc. 1 Never Married 2 Married 2X No Yes If Yes, Give Year 4 X Divorced 1 Yes 2 X No specify: Specify: White ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical ltimore, MD 21215-0036 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Max Guethler, Jr. Gladys Mueller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 212 Post Road, Rising Sun, MD 21911 Brian Guethler / Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 09/01/2012 West Nottingham Cemetery Colora, MD 4 Donation Other Specify 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of uneral Service Licens 111 S. Queen Street, Rising Sun, MD 21911 23a. Parta. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Acute Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attending Physiciao: The law requires that the death certificate be executed 24 hours after death. Gal AMENDED 23a, 27, 28a-f, per me, g931 9-6-12 sm **X** UNPENDED attending physician for use as the burial -Physician/Medi Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Por 1 Yes 2 No 9 Unknown Unknown by the a signed by t be detache P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Records. this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25 Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 V Yes No To the Funeral Directur: After t completely filled in by the funeral 28a. Date of Injury (Month, Day,Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural To the Hospital or Attendia within 24 hours after death.

To the Funeral Directur: subject ingested ethanol 1 Yes 2 X No Pending fd 8-22-12 fd 05:00 and 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 212 Post Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be Single Family Home (Specify) Rising Sun, MD. Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 22, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month State

DHMH 17 Rev 1/2001 OCME 2006

Registra

AUG 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08/09/2012 CHING HAN 1:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Fox Chase Nursing Home Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 XM 2 ☐ F Days Hours Min 90 0472171922 China Director Yrs 577-66-2269 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Montgomery Rockville 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 199 Rollins Avenue, #411 20852 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ Black, White etc. 1 Never Married 2 Married ☐ Yes 2 X No ò Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give "natural", Specify: 3 Widowed 4 Divorced Completed Chinese Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Coilege (1-4 or 5+) Plumber 8th Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Shiu Fen Han - wife 199 Rollins Avenue, #411, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Parklawn Memorial Pk | 08/11/2012 Rockville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Servi 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death MONTAS Immediate Cause (Final Physician. Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Ties Control Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 🗌 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending s after death. 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Direct completed filled in by 4 Homicide determined 24 hours a Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗔 within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D28656 08/10/2012 dress of person who completed cause of death (Item 23a) (Type, Print) LSSI, MD 15245 Shady Grove Road, Rockville, MD 20850 Ravi Passi, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 1 4 2012

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00A. August 18 ay 2012 ear Janet Louise Hastings Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's **Examiner** 4b. City, Town, or Location of Death Morningside House of Laurel Laurel 5. Social Security Number 201–18–6040 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Permisylvania 7. Age (In yrs. last birthday) 8 Date of Birth 1 □ M 2 🕅 F Months Hours Delenth 304, 1927 Yrs. 84 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 United States 7700 Cherry Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 ☒ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Snider ည Rebecca Oyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Hastings -son 6715 Bonnett Court Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State George Washington Cen. 8/22/2012 Adelphi, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ውስምተው የም፡፡፡Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final dugreed disease or condition resulting in death) zheimers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical

Physician/ Medical Examiner

**Funeral** 

**Director** 

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"natural"

Il Hygiene.

th and Mental F 27 is marked of traumatic even ge 1 and 2 should be fil it of Health and Mental : If item 27 is marked

other

P Department o Important: If any injury or

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filed within 72 hours after

Baltimore, Maryland 21215-0036

physician and the burial-transit attending pl ρ Jas

To the Hospital or Attending Physician: within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Completed by

Be

Certificate: To

Medical

only one) 29b. Signature and 🎢 e of 🤉

Stuart J. Turkewitz,

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

State

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🔲 Ectopio			23d. Date of delivery Month Day Year
Part II. Other significant conditions of Hypertens; Porkinson'	ontributing to death but not res	sulting in the underlying fhyroia	g cause given in Part I.		use contribute to the cause of death?
Porkinson'	s Disease	<u> </u>		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 💢 I	No 1 🗆 Yes 2 🔀 No
25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
(Check 2 Medical Exami	sician: To the best of my know iner: On the basis of examinatio se <b>Practione</b> r: To the best of m	n and/or investigation, i	n my opinion, death occurred	at the time, date and plac	e, and due to the cause(s) and manner state

29c. License number

D31001

M.D. 7500 Greenway Center Drive, #430 Greenbelt, Maryland 20770

29d. Date signed (Month, Day, Year)

August 20, 2012

Registrar DHMH 17 Rev 7/2009 10

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		,	1 - For State Registrar	State of M	laryland / De	partmen ertificat					Reg. No.	2012	279	901
	Physici	an	Decedent's Name (First, Middle, La							2. Date of De. Month	Day	2012	3. Time o	
	/Media			ohn Robert						August				Рм
١	Examir	er	4a. Facility Name (If not institution, give		)			Location of	of Death			County of Dea	ath	
			51 Cynthia Court 5. Social Security Number 6.5		ge (In yrs. last birtho		kton	I If Under	24 Hrs.	8. Date of Birt	h	Cecil	rthplace (State	or Foreign
	Funeral Director			MM 2□E	68 Yrs	Months		Hours	Min.	FEB 5	v. Year)	- C	ountry) elaware	
			Usual Residence of Decedent							1110 0,	1/77		CIAWAIC	
	how		10a. State 10b. County		10c. City, Town o	r Location							10d. Inside C	
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	or 24	Dire	10e. Street and Number			10f. Zip						en of What C	•	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If tem 27 is marked other then "natural', or items 23e or 28e-1 show importent: If tem 27 is marked other then "hattural", or items 23e or 28e-1 show any highly or other traumatic event, the Medical Examinar must be notified at ance.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐	?	If Yes, spe	dent of Hi cify Cuba	ispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	.   1	<ol> <li>Race - Am Black, Whi</li> </ol>		
21215-0036	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	_	1 🗆 Yes	2 X No	Specify:			3	Spacify: W	hite	
9	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usu	al Occup	ation			16b. Kin	d of Business		
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pu	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "natural", ' raumatic event, I're Medical Exa	Be	17. Father's Name (First, Middle, Last	)			į			(First, Middle,	Maiden S	Sumame)		
<u></u>	Mental Merked o	은	John D. Haase				-		2002	dfield				
Maryland	and I and I		19a. Informant's Name/Relationship			_				Route Numbe	-		Zip Code)	
	1 and Health		John R. Haase, J	r./Son	20b. Place of D					ton, M		921 ation - City o	r Town State	
Baltimore,	H ltd		1 ☐ Burial 2 ☐ Cremation 3 [		e cemetery,	crematory or c	other plac		_	t 24,				
ţ	permit. Page Depertment Importent: If any injury o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		R. A. Fe					alsa II.aa			ster, F	
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			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.			-		,			Interval Be Onset and	tween
1	Physician /Medical		disease or condition resulting in death)	a. Non S	sacrequence of	ncer	Lu	no					1 year	~
н	Examiner			CASON	mall (a) s a consequence of)	بمحا	1.5		4				5,000	c4.
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence of):	14	- Ori	50~					byca	
	death certificate be executed attending physicien end of for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o. Hype	rtensio	~							5year	ars
0,	e exe ien ei urial-t		resulting in death) Last	Due to (or a	s a consequence of):									
8760,	ate by hysic the bu	edical		_ d										
9	leath certifica attending ph I for use as th	Mec	IF FEMALE:										1	
Вох	ath co	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p					2:	3d. Date of de Month		Year
	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	5 Other (sp	oecify)						,	
P.O.	requires that the de been signed by the a hould be detached t	P.	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying o	ause div	en in Part I		23e. Did t	obacco us	e contribute t	to the cause of	death?
ds,	sign d be	d by		,	•	, , ,				1 🔑	fes 2□	]No 3 □ P	robably 4 🗆	Unknown
of Vital Records,		Completed								24a. Was	20	24h Woro a	utopsy findings	available
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la	sician: Th certificate rector, pag	ပိ	25. Was case referred to medical	I				OC D1	( D 1)	1 ☐ Yes	2 0 No	1 □ Ye	s 2□No	
S	Physician: r this certifice ral director, I	To B	examiner? 1 ☐ Yes 2 ☐ 10	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpa	itient 3 □ D0	Oth	00		(Check only one 5 Residue)		□Other (So	ocifu)	
o		T.	27. Manner of Death	28a. Date of Inj (Month, D			28c. Injun Worl			8d. Describe			BCHY)	
Division	Attending I r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year) Inju	M M		k≀ Yes 2□	No					
Vis	er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of in	njury - At home, farm	, street, factor	y, office		2	28f. Location (: City or Tox		Number or F	Rural Route Num	n <i>ber</i> ,
Ö	tal or rs afte al Dir ed in	Certification:												
	tospi t hour uner	edical	29a. Certifier 1 ☐ Certifying P	nysician: To the bes miner: On the basis	t of my knowledge, d	eath occurred	at the tin	ne, date an	nd place, a	and due to the	cause(s) a	and manner a	is stated.	s)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medi	one)	and manner s	tated.									<del>-</del> /
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	8		Jose Wh	IVUD.			)44	116			tug u	st 2	0, 20	1 4
	N		30. Name and address of person who					4/4	$\Omega$	2.0	2 /			
	Ch	•	31. Date filed (Month, Day, Year)	W. Hig	trar's Signature	工厂	ON	\ <u>۱۷۱</u>	، ب	219	41			
	Sta	ne .	AUG 3 0 2012	Marie A.	A Mark									

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 For			d / Depa	artment of H	lealth and	d Mental Hyg		27902
		- (0	1 - State Registrar  1. Decedent's Name (First, Middle,	Lock		Cei	rtificate of I	Death	2. Date of Dea	og. Iter	3. Time of Death
1	Physici	an							Month	Day Year 2012	
	/Medio		Robert Gustave  4a. Facility Name (If not institution,				4b. City, Town, or	Location of De	August	4c. County of Dea	
* . W	LAdmin	انا انا ب	Coffman Nursing	Home			Hagersto	wn		Washing	ton
多	Funeral Director				e (In yrs. i	iast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	frs. 8. Date of Birth (Month, Day June 07	, Year) 9. Bii	rthplace (State or Foreign ountry)
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	ncation				10d. Inside City Limits
	Aaryla Febor	ŏ		to a se		,					1X Yes 2 □ No
	28a-	Director	Maryland Washing 10e. Street and Number	, LOII	пад	erstow	10f. Zip Code			0g. Citizen of What C	ountry?
	h with		1304 Pennsylvan	ia Avenue			21742			U.S.A.	
	ems .	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? in, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar mark the multiled at once.	by	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced				1□Yes 2⊠No			Specify: W	
5	72 ha	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of	working	16b. Kind of Business	s/Industry
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ф 5	filed Hygid Sther		12 17. Father's Name (First, Middle, La	ast)				18. Mother's I	Name (First, Middle,		
lan	Med c	To Be	Robert Bently H	ammond				Hedwi	g L. Muen	ch	
ary	shou and N s mai		19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	and Number or	Rural Route Numbe	r, City or Town, State,	Zip Code)
	and 2 salth n 27 i		C. LuAnn Hammon	d / Daughter						n, Marylan	
ore	ges 1 of He If itan		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □Removal from State	20b. P	lace of Dispo emetery, cre	sition (Name of natory or other plac		Date	20c. Location - City o	
Baltimore,	t. Pag tmen tent: tent:		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Res		en Cemete:				n, Maryland
Ba	Department of the control of the con		21. Signature of Funeral Service Li	Sun			2. Name and Address Name and Penns			en Funeral erstown, M	aryland 21742
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. END	ne. STAGE	E Ita	er the mode of dyin		diac or respiratory arr	est,	Approximate Interval Between Onset and Death MOUTHS
П	Examiner			Due to (or as		uence of):					Manny -
(k)	*	ler	Gagueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		uence of):					110011113
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x 68	sertificat ding phy se as th	/Med	IF FEMALE:	23c. If yes, outcome	of orogona	1001					
S. Box	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant at	2 🗌 Fetal	I death 3[	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
P.O.	hat the	Phy	Part II. Other significant condition	s contributing to death h	uit not resi	ulting in the u	nderlying cause give	en in Part I	23e Did to	bacco use contribute	to the cause of death?
ords,	w requires that been signed t should be det										robably 4) Unknown
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ita	ian: ortifice ctor. p	BeC	25. Was case referred to medical examiner?				_	26. Place of I	Death   Check only or	100	3 LE 110
	hysic his ce	P	1 ☐ Yes 2 ◯ No			ER/Outpatier	nt 3 DOA Oth	er: 4 Nursin	g Home 5 ☐ Resid	ence 6 □Other (Sp.	ecify)
D C	ing P	ino i	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Wor	k?	28d. Describe h	ow injury occurred	
sio	ttend death ttor: /	icati	2 Accident investiga 3 Suicide 6 Could no	nt he	un. At be			Yes 2 □ No	29f Location /C	troot and Mumber of S	) ( D 4- M 1
Division of	s after all Direct	Certification:	4 Homicide determin	building, et	c. (Specify	y)	eet, factory, office		City or Tow	treet and Number or F n, State)	tural Houte Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page.	Medicai (	29a. Certifier 1 VP Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner sta	f examinat	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time, o	ause(s) and manner a late and place, and du	is stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date signed (Mor	oth, Day, Year)
	1		> Y Oled	w/			Di	46561		Ang 20	2012
	Ø		30. Name and address of person w		har		· f-	ยนเกษา	MD .	Le740	
	Sta Registr		31. Date filed (Month, Day, Year)  AIIG 3 0 2012	32. Registr	ar's Signa	1411	(1,(0)				
*	200	2	HAM A A MA.	MATTER PO	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August  $17^{\text{Day}}$   $2012^{\text{Year}}$ Samuel Joseph 9:45P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 578-10-3736 1 🛛 M 2 🗆 F Hours Min. May 1th Par 9917 Wastrington, DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road, #RC1326 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 X Yes 2 No If Yes, Give 043–1946 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supply Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Joseph Sarah Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Horse Chestnut Court Mt. Airy, Maryland 21771 Michael Joseph -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 8/21/2012 Silver Spring, Maryland Signature of Funeral Service Licenses Bollald Vires Bolle Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phylician Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or ilinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 ☐ Yes 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2**X** No မ within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🛚 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julaine Harding, NP 3110 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of	Marylar		artment of F tificate of L		and M		_	201	2	27001
			Registrar  1. Decedent's Name (First, Midd.	le, Last)		Cer	uncate of L	Jean		2. Date of Dea	Reg. No	o. <u>Z</u> U	4	2 / 9 U 4 3. Time of Death
	Physicia Medic		Hazel Ruby	Kolpack						OS / 1	7/	2012	ear 2	3:50 PM
	Examin	er	4a. Facility Name (if not institution	· -			4b. City, Town, or		of Death			County of		
	Funeral		Lions Center Re 5. Social Security Number		. Age (In yrs. I	ast birthday)	Cumber1a If Under 1 Year	and I If Under	24 Hrs.	8. Date of Birt		Allega		ace (State or Foreign
	Director		216-22-0173	1 □ M 2 🔀 F	8	S5 Yrs.	Months Days	Hours	Min.	(Month, Day 01/14/1	y, Year)		Count	inia
	and show	ò	Usual Residence of Decedent  10a. State 10b. County	/		y, Town or Lo	cation							d. Inside City Limits
	Maryla 28a-f otifiec	Director	MD Alleg	any	L	ittle (	Orleans							1 ☐ Yes 2 🛣 No
	ith the 3a or it be n		10e. Street and Number 32306 Mudlick	Pond			10f. Zip Code 21766				10g. Ci	itizen of Wha	t Count	ry?
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show Aedical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S		Vas Decedent of Hi	spanic Orig	gin? (Spe	cify Yes or No-	057	14. Race - /	America	ın Indian,
36	after d I", or i kamin		1 Never Married 2 Ma	If Van Cive	9s? X No		Yes, specify Cuba	84		Rican, etc.)		Black, V Specify:		
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215	within 721 rgiene. <b>ner than "r</b> <b>t, the Med</b>	Completed by	Elementary/Secondary (0-12)	est grade completed) College (1-4	or 5+)	(Give A	ind of work done d NOT use retired)	luring most	t of workir	ng				ustry
d 21	filed within al Hygiene. d other thar event, the N	Be C	12 17. Father's Name (First, Middle,	l ast)		Sch	ool Teac		!- NI	(First, Middle,		ucatio	n	
/lan	1 and 2 should be filed within 72 hour of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	인	William Finch	·						enkins	iviaiden	Surname)		
lary	should and N is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Numbe	er or Rural	Route Number	r, City or	r Town, State	, Zip Co	ode)
e, N	and 2: Health em 27 ther tr		Philip J.Kolpac	k,Jr./Son	20h E		Windingwa	ay We		inister				
mor	age 1 ent of nt: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 6		tate c	emetery, crem	iatory or other place			ate /2012		ocation - Cit		
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If it any injury or of		21. Signature of Funeral Service		LTII		Name and Addres			l West		le Or n Stre		is, MD
ш	20 E 8 3		20g Port 1 Sator the diseases	Mou	MOO2		ove Fune		lome,	P.A.Han	coc		175	
	Physician/		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final			- 1				respiratory arr	est,			Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or	as a consequ	uence of):	final Be		_		_		1 '	veeks
		er	Sequentially list conditions,	D. —			rual 1st	lexo	7				a	seeles
	ited d ansit	amin	cause. Enter Underlying Cause (Disease or injury	Director.	аві в польнов	Nemes OI,								
	e execuian and	edical Examine	that initiated events resulting in death) Last	Due to (or	as a consequ	ience of):	**			,		•	$\top$	
200	cate be executed physician and s the burial-transit			d			-					_	+	
Box 68760	certifi ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy					23d. Date of	deliver	y
Bô	death the atte	Physician/M	in the past 12 mpnths? 1 ☐ Yes 2 X No 9 ☐ Unknown		nt at time of c		Other (specify)	У				Month		Day Year
P.0.	hat the led by detact	by Ph	Part II. Other significant condition	ons contributing to deat	th but not res	ulting in the ur	nderlying cause give	en in Part I		23e. Did to	bacco u	use contribut	e to the	cause of death?
Division of Vital Records, P.O.	quires t	ted b	Dement	(k						1 □ Y	es 2	□ No 3 □	] Proba	bly 4X Unknown
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Vita	ysicia is certi direct	To Be	examiner?	Hospital:	patient 2 🗆	ER/Outpatient	Othe	r: 4 Mun		o <i>nly one)</i> ne 5 🗆 Reside	ence 6	□ Other (S	necify)	•
اه ر	ing PP		27. Manner of Death  1 → Natural 5 □ Pendir	28a. Date of in (Month,	injury Day, Year)	28b. Time of injury	28c. Injury work?	at	2	8d. Describe ho			2001197	
Sior	Attend r death ctor: / by the	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 280 Place of	Injury - At ho	me, farm, stre	M 1 L	Yes 2 🗆	_	8f. Location (St	reet and	d Number or	Rural B	oute Number
Σ	tal or rs afte al Dire		4 - Homicide determ	building,	etc. (Specify)					City or Town			77070271	outo rumbor,
	Hosp 24 hou Funer etely fil	Medical	(Check 2 Medical E	Physician: To the best xaminer: On the basis of	of examination	and/or investig	gation, in my opinior	n, death occ	curred at t	he time, date an	d place.	and due to t	he caus	e(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner: To	tne best of m	ny knowledge,	29c. License	number				(s) and manne te signed (Mo		
	(N~		· Ju	w /			D002	112	+4		81	18/12	2	
	21.		30. Name and address of person	who completed cause o		23a) (Type, Pr BYWA		inct	tric	a nic	) ~	DIEZ	2	
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	Registra	r	AUG 3 0 201	2 /2	1	1								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Connie Jean Keaton 2012 16:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Cumber land Allegany 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours **Director** 233-54-4950 1 🗆 M 2 🗓 F 77 Dec.2,1934 Maryland Usual Residence of Deced 28a-f show 10a. State with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director be notified WV Hampshire Springfield 1 Yes X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 275 Tupelo Loop 26763-5259 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No 9 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give White 'natural", Specify: 3 X Widowed 4 Divorced Completed Year or Dates than "natura he Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and III. A seeman and a seeman and a seeman and a seeman and a seeman are transments and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman and a seeman a seeman and a seeman and a seeman a seeman and a seeman a se Elementary/Secondary (0-12) College (1-4 or 5+) Teacher School Be Page 1 and 2 should be filed in ment of Health and Mental Hyyant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Henry Ansel, Jr. Helen Catherine Kauffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Jean Haines, Daughter 347 Tupelo Loop, Springfield, WV 26763-5259 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Dat 2012 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other Springfield Hill Aug. 22, Springfield, WV Signatu of Funeral Si 22. Name and Address of Facility Scarpelli tuneral Home, P. A. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. equipted Cause (Fine) 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Nonischonic disease or condition Medical resulting in death) Examiner Securetially list over the con-Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the attending physician and ched for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed this certificate Yes 2 ON To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 DKNo 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, s after death. Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practition of T. the best of my investigation and occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68455 6 gm MD 8/18/12

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who con

MD 12501 Willowbrook Rd. Cumberland, MD 21502

mpleted cause of deat (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 2012Bernard A. Kolb Sr. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northampton Manor Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth Funeral Days (Month, Day, Year) Director 217-32-5704 1 XM 2 □ F 94 Maryland Aug. 9 1918 tal Hygiene. ad other than "natural", or items 23a or 28a-f sho: event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Frederick Adams town 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2531 Ballenger Creek Pike Funeral 21710 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Earl Edward Kolb Nellie Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Kolb Jr. (Son) 2190 Park Mills Rd., Adamstown, MD 21710 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
Olivet Cemetery 1 ABurial 2 Cremation 3 Removal from State 8/21/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Keeney & basford P.A. Funeral Home 106 E. Church St., Frederick, MD 21701 21. Signature of Funeral Service Licensee MO1612 23a. Part 1 Énter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a sa consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 1 Yes 2 9 Unknown cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available 24a, Was an Was autopsy performed?

Yes 2 No prior to completion of cause of death? certificate has 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours a To the Funeral D completely filled it Medical 29a. Certifier 1 🖔 Certifying Physician: ib the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 8-21-12 10 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hense Ave MD 21701 MD Zaidi 801 TOLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	arylan	d / Depa	artment of H	lealth and	Mental Hy	giene		
		_	_ State Registrar		Cer	tificate of D	Death		Reg. No. 20	12	27901
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	_	Year	3. Time of Death
	Medic	al	MARTHA HARTER LOUDEN					Augus			8:35 P M
	Examin	er	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or		ath	4c. County	of Death	
~	Funeral		Brooke Grove Rehab, and N 5. Social Security Number 6. Sex / 7. Ag	ursir e (In vrs. k	ng ast birthday)	Sandy S	OF LING If Under 24 Hr	s. 8. Date of Bir	th	gome:	ry_ place (State or Foreign
	Director		233-26-9076 1 DM 2 VF	91	Yrs.	Months Days	Hours Mir	n. (Month, Da Mar.	18, 1921	Coun	
	» Mo	,	Usual Residence of Decedent					1222	20,2322		
	ryland -f she ied at	Director	10a. State 10b. County	· ·	y, Town or Loo	cation				1	1 ☐ Yes 2 ☑ No
	e Ma r 28a notif	Dire	MD Montgomery  10e. Street and Number	01	ney	10f. Zip Code			10g. Citizen of V	Ibak Caus	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at		19321 Madison House Street			20832			United		
	eath v	Funeral	11. Marital Status 12. Was Decedent I			Vas Decedent of His					can Indian,
9	ter de , or it	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☑			Yes, specify Cubar		rto Rican, etc.)		k, White,	
003	urs af tural" al Exa	Completed	3						Specify:	Whit	æ
15-	72 ho "na' ledica	uple	15. Decedent's Education (Specify only highest grade completed)		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		orking	16b. Kind of Bu	siness/Ind	dustry
72	within giene. er thar , the M	Con	Elementary/Secondary (0-12) College (1-4 or 5	i+)		maker			Own Ho	ome	
þ	filed wall Hyging I othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,			
Maryland 21215-0036	should be file and Mental I 7 is marked o raumatic eve	To	Joseph	Н	larter		Lena	Rachel S	Simmons		
lan	should and N is ma	48	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or F	Rural Route Numbe	er, City or Town, Si	ate, Zip C	Code)
≥	and 2 s Health a tem 27 i		Nancy L. Coffman/daughter			Madison	House S	St., Olne			
ore	ge 1a It of H If ite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	C	emetery, crem	sition (Name of natory or other place		Date	20c. Location -	•	wn, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)	Nor		lem. Cem.		17/2012	Olney, M		
Bal	permit. Page Department o Important: If any injury or once.	ļ	21. Signature of Juneral Service Light		22	Name and Addres	s of Facility Mi × 5038.	uriel H. Taytons	Barber I	uner	cal Home
			23a. Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death	n. Do not ente						Approximate Interval Between
	Fh_sician/	0.00	Immediate Cause (Final disease or condition Athero	sclei	rotic \	/ascular	Disease			1	Onset and Death
أميدا	Medical Examiner		resulting in death)  Due to (or as a								
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9 ×	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 mooths? 23c. If yes, outcome	2 Feta	l death 3 🗌	Ectopic pregnancy	У			e of delive	
P.O. Box 687	requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/M	1	t time of d	leath 5 L	Other (specify)			Mor	ш	Day Year
Ö.	hat th ed by detac	y Ph	Part II. Other significant conditions contributing to death b	ut not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contri	bute to th	ne cause of death?
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₹	hysic his ce al dire	2	1 ☐ Yes 2 ☐ No Hospital:		ER/Outpatien	t 3 DOA Othe	r: 4 Wursing	Home 5 Resid	dence 6 Othe	(Specify)	)
סר	ing P	Certificate:	27. Manner of Death  1 Watural 5 Pending  28a. Date of inju (Month, Day)	ry y, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	now injury occurre	t	
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Division of Vital Records,	al or A s after I Dire		4 Homicide determined building, etc			,,,		City or Tov		or ribrar	rione rumbes,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check Deck Medical Examiner: On the basis of e	xamination	n and/or invest	igation, in my opinio	n, death occurre	d at the time, date a	ınd place, and due	to the cau	use(s) and manner stated.
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	= pest of m	iy knowledge,	death occurred at the		place, and due to	the cause(s) and m 29d. Date signed		
			Murerallot	Tue	n, Mi	D-005	7630		August 1	3, 20	012
	3		30. Name and address of person who completed cause of d	eath (Item	23a) (Type, P						
	6					re., Silve	er Spri	ng, MD	20902 S	<u>uite</u>	209
	Stat Registra		31. Date filed (Month, Day Year) 5 2012 32. Registra		ure .	and					
	ricgiotic				- 1						

Registrar

31. Date filed (Month, Day, Year)

AUG 1 4 2012

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

M.O. 6121 MONTROSE

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Shirley Maxine Morris 7:05 PM Aug 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery 4b. City, Town, or Location of Death Genesis Springbrook Nursing Home Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 577-44-1654 80 Yrs 8/9/1932 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Washington None 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20011 United States 737 Longfellow St., N.W. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. African 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington Hospital Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Hamilton James S. Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rock Creek Cemetery | 8/16/2012

8000 Bullfinch Place, White Plains, MD 20695

22. Name and Address of Facility McGuire Funeral Service, Inc.

20c. Location - City or Town, State

Washington, DC

August 13, 2012

1 - State Registrar

10a. State

DC

Tania Hester - Executor

4 ☐ Donation 5 ☐ Other (Specify)

1 X Burial 2 Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan M. Ginsberg, MD

Day, Year)

AUG 1 4 2012

31. Date filed (Month

20a. Method of Disposition

21. Signature of Funeral Service

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

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Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r

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injury or other

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner Examir

tran attending physiciar Physician/Medical nse Por the ρ signed by the period of the period of the signal of the si Completed page 2 s has Be မ After this funeral Certificate: nours after death.

neral Director: A
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State

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

7400 Georgia Ave., NW, Washington, DC 20012 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endstage renal disease disease or condition resulting in death) Due to (or as a consequence of Hypertension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? chronic obstructive lung disease 1 Yes 2 No 3 Probably 4X Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autopc, performed? death? 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗆 Homicide City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

D26564

6570 Kenilworth Ave. Riverdale, MD 20737

20b. Place of Disposition (Name of

Registrar

within 24 hours a

To the Funeral D

completed filled i

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Curtis Martin Mitchell August 11, 2012 7:50 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mount Airy Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign July 4, 1968 Days Min. <sup>Country)</sup>Virginia Director 215-76-1075 1 X M 2 □ F 44 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 X Yes 2 ☐ No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Fidler Lane 20910 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 Married Black, White, etc. ģ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced If Yes, Give Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7/ ment of Health and Mental Hygiene, ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Claims Adjuster Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Mitchell Dorothy Dexter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Meyers / Sister 8233 Fox Hunt Lane, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of 8 20c. Location - City or Town, State Auguste 14. any Injury or conce. 1 🗌 Burial 2 🕅 Cremation 3 🔲 Removal from State Smithsburg Crematory Important 4 ☐ Donation 5 ☐ Other (Specify) 2012 Smithsburg, Maryland 21. Signature of Funeral Service Licens Reeney and Basiford PA Funeral Home, E. Church Street, Frederick, Maryland 21701 23a. Fat 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ Onset and Death disease or condition resulting in death) alioblastoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated sever injury) Examine Duri to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 🗌 Yes 2 **N**O Other: HUSPICE How 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy Frederick, Eskander 501 MD 2170

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Morth, Day, Year)

32. Pégistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ SHIRLEY ANN MARSHALL AUGUST 8:11 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT 7838 RADCLIFFE ROAD 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗶 F Months 78 Yrs. 10/11/1933 MARYLAND Director 217-28-3569 Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director items 23a or 28a-f s ner must be notified 1 Yes 2 X No CHESTERTOWN MD KENT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 7838 RADCLIFFE ROAD 21620 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 9 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the OWN HOME 12 HOMEMAKER traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ AUBREY HOGANS EVELYN COLLIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is . any injury or other traumonce. 7834 RADCLIFFE ROAD CHESTERTOWN, MARYLAND 21620 WILLIAM MARSHALL / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) CHESAPEAKE CREMATION 08/08/2012 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS. HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Keik 30 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or comblication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Physician OBSTRUCTIVE PULMONARY HRONIC LOYN disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit death certificate be executed and Due to (or as a consequence of): resulting in death) Last physiclan a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OSTEDPOROSIS WITH SPINAL KYPHOSIS 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Director: After this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending within 24 hours a

To the Funeral C 2 5

after

State

Medical

4 Homicide

29b. Signature and title of certific

29a. Certifier (Check

completed cause of death (Item 23a) (Type, Print)

determined

hestortown

Registrar

Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D004158

29d. Date signed (Month, Dav. Year)

12-06239 Max Myers

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Ce	ertificate	of	Death				F	Reg. No		0 ;	
Physicia	an/	1. Decedent's Nam		. ,	**					· ·		ate of Dea	ath			3. Time of Death
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Mary r 28s	Director	10e. Street and Nu						10f. Zip Code				1	0g. Cit	izen of Wh	at Cour	ntry?
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215 e file ntal H ked o	Be (	]	H. Nel:	son Myers							•	otho		ourname,		
21 Sould b	P	19a. Informant's Na				19b. Ma	iling A	ddress (Str	eet ar					ity or Town	. State.	Zip Code)
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>		Marie	Myers	/Wife				adowv:								
Heal I and I tren	ſ	20a. Method of Disp		. 🗆	20b.	Place of Dis	positio	on (Name of c	emet	ery,	Date	9	20c.	Location - (	City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 37 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 Donation 5		3 Removal fr	om State Par	rklawn	s N	place) demoria	a1	8	/23/	12		Chambe	ersb	ourg, PA
mit. I sartm	ŀ	21. Signature of Fur						ne and Addre	ss of	Facility 7	immo	2°m 0 10		_		eral Home Inc.
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Physician	一	23a. Part I. Enter the failure. List onl	e disease, or	complications that c	aused the death	. Do not ent	er the	mode of dyin	g, suc	ch as cardia	c or respi	iratory arre	est, sho	ck, or hear	t	Approximate Interval
/Medical Examiner		Immediate Cause (F		on each line. a. Head Injury	,											Between Onset and Death
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Box 68 e death certiinthe attending ed for use as	Physicia	1 Yes 2 N	o 9 🔲 Unki	-		ain 5	Other	(Specify)					1			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	c I	1 Natural	5 Pendi	(Month,		1100 hrs	zi iliyal			2 No		ect fell d				
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17/11	3	0. Name and addres	ss of person v	no completed cause	e of death /Item	23a)		L					-90			
, ,		Laron Locke		sistant Medical			Baltin	nore Stree	et, B	altimore.	MD 21	1223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year CAROL LEHOSKY MAHON М 20 AUGUST 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS WALDORF CENTER WALDORF CHARLES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min. AUG. 19, Year) 9 4 3 577-56-7749 69 WASH", DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4140 OLD WASHINGTON ROAD 20602 U. S. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 1 Never Married 2 Married Black, White, etc. ☐ Yes Yes, Give 2 X No 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) BANK TELLER MD BANK AND TRUST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, JOHN LEHOSKY MARY BOHIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN B. STEWART/SON 1030 NORFOLK DRIVE, LA PLATA, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State emetery, crematory or other place METRO. CRÉMATORY 8-21-2012 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Cr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Advance disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a... autopsy performed? Yes 2 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse been signed by t should be detach Completed by within 24 hours after death.

To the Funeral Director: After this certificate has æ 은 Certificate:

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

72 hours after death

al Hygiene. I other than "

and Mental F is marked of

permit. Page 1 and 2 should be 1. Department of Health and Mental. Important: If item 27 is markany injury or other 27.

Physician/

Medical Examiner

Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

2 Accident
3 Suicide
4 Homicide

29a Certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 27. Manner of Death Natural 5 Pending

Investigation

determined

injury

28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No.

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

address of person who completed cause of death (Item 23a) (Type, Print)

Spangler 6095 Marshallee Drive Elkridge 31. Date filed (Month, Day, Year)

State Registrar

in by t

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 27914

		1- For State Registrar			Certific	cate of	Death				1	Reg. No	<b>)</b> ,		
Physic Medical Exam	ian/	1. Decedent's Name (First, Mide Adrian Antonic									Date of De	ath		r	3. Time of Death
The state of the s		4a. Facility Name (if not instituti		umber)		14	. City, Town,	orloc	ration of D		Month ugust 2		c. County o		1349 hrs
		Prince George's Hos	· <del>-</del>	unibor)		"	Cheverly	, or Loc	allon or D	eatri			Prince G		
Funera		5. Social Security Number	6. Sex	7. Age (In y	yrs. last bi	rthday)	If Under 1 Y	ear I	f Under 24	4Hrs. 8.	Date of B			9. Birt	thplace (State or
Director		771-16-2751	1 M 2 F		23	Yrs.	Months D	ays	Hours	Min.	Apr.1	1.1	989	Foreig Co	n untry) Jamaica
<b>*</b>		Usual Residence of Decedent													
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Aaryland 28a-f show 1 at once,	ફ	10e. Street and Number	Arundel		aurer										1 Yes 2 No
72 hours after death with the Maryland n"nuatural", or items 23a or 28a-f sho	Director	8320 Green Gra	iss Road				10f. Zip Code	e )724				-	nited		•
with the s 23a e noti	<u></u>	11. Marital Status	12. Was Dec	redent Ever	in II S	13 W/as	Decedent of			/ Facaif	. Van az N				
leath r r item	Funeral	1 X Never Married 2 N				If Yes	, specify Cut	ban, Me	exican, Pu	erto Rica	in, etc.)	٥	White,		can Indian, Black,
after o		3 Widowed 4 Di	vorced If Yes, Give Yes		NO	1 Y	es 2 🛚 I	No s	ecify:				Specify:	Bla	ack
hours natur Exam	Pe	15. Decedent's Education (Spe				Decedent's	Usual Occupt of working I	pation (	(Give kind	of work	done	16b.	Kind of Bus		
36 bin 72 than	Completed	Elementary/Secondary (0-12)	College (				Offic			, от оа,		Pr	rime (	boro	e's County
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21215-0036 21215-0036 ould be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be	Clayton Morris							herri				ourname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours aft pergerment of Health and Mental Hygene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medica Examine	ုင	19a. Informant's Name/Relations			19	b. Mailing A	ddress (Str	reet and	d Number	or Rural	Route Nu	mber, C	ity or Town	, State,	Zip Code)
MD and 2 sho saith and 2 sem 27 is		Sherrin Crosda 20a. Method of Disposition	ile -mothe			_	reen G	_							
Ore		1 X Burial 2 Cremation	n 3 Removal fr	om State	cremat	ory or other			*	Dat			Location - (		
Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 Other S, 21. Signature of Funeral Service			Lakemo		orial G			/28/2					, Maryland
Ba perm Depa Impo injur		21. Signature of Fullerar Service	Bogu	a Di		Don's	Para Addres	esset F	rgwar	tlt l	Funer	al	Home,	PA	1 1 0070
Physician		23a. Part I. Enter the disease, or	complications that complications	aused the de	eath. Do no	ot enter the	mode of dyin	ler ig, such	l <sup>M</sup> IIII n as cardia	KOA0	DE J	ESV est, sho	LLLE, or hear	Ma 1	ryland 2070 Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease		ıries											Between Onset and Death
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8760, tificate be ex ng physician as the burial -	n/Medical	IF FEMALE:	23c. If yes, o	outcome of p	regnancy		-,	_				22-	l Data of d	a live a se	
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Box 68 e death certi the attendin ed for use as	Physicia	1 Yes 2 No 9 Unk	rnown 9 Unkno	ant at time of	fdeath 5	Other	(Specify)								
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Vita hysici this c	일	examiner? 1 ✔ Yes 2 No	Hospital: 1 Ir	patient 2	<b>✓</b> ER/Ou	tpatient 3		Other		sing Hom		Resider	nce 6	Other:	
ding Ph		27. Manner of Death  1 Natural	28a. Date of (Month, Aug 20, 2	of Injury Day, Year)		ime of Injur	′ I ′	-					ry occurred		
SiOr Attend death death sctor:	ğ	5 Pend	tigation		1258				2 No	Diive	or aut	O IIIVC	nved in C	Ollisio	011
Division or At cours after districted in by filled in by	Certification:	deter	Thor bo				actory, office	buildin	g, etc.	1 0	r Town, S	tate)			Route Number, City
Tospit 4 hour 'uners		20a Cartifat	10,000.77	Major Ro		<u> </u>	-1.10 1/	1-1-					fill Road, f		
Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 1 ☐ Certifying Phone) 2 ✓ Medical Exam	ysician: To the best niner:On the basis of	examination	n and/or in	tn occurred vestigation,	in my opinio	date an n, deat	d place, ar h occurred	nd due to d at the ti	the cause me, date a	e(s) and and plac	d manner as ce, and due	to the	cause(s)
F. 2 F. 8	₹.	29b. Signature and title of certifier	and manner sta	ated.			29c. Licen								ı, Day,Year)
Jan Cal		DINCE	•				O.C.	M.E.					ust 21, 20		
120	t	30. Name and address of person		of death (Ite	em 23a)		l								
		Donna M. Vincenti, MD				900 W.	Baltimore	e Stre	et, Balt	imore,	MD 212	223			
Sta Regist		31. Date filed (Month, Day, Year)  AUC 3 0 201		istrar's Sign	ature	ه م									
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			For State Registrar	State of Marylan		artment of H			201	2 27015
ľ	Physicia		1. Decedent's Name (First, Middle, Last)  Teyald L	Russell		imodio or B	- Catiff	2. Date of Dea Month	Day Year	3. Time of Death
100	Medi Examir		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or I	Location of Death	AUGUST	17 201 4c. County of Dea	
-	Ž.		CHAS.CO.NURSING	& REHAB. (	CNTR.	LA PL			CHARL	
	Funeral Director		5. Social Security Number 410-54-9513  Usual Residence of Decedent	7. Age (In yrs. It			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day FEB . 19	v, Year) Co	rthplace (State or Foreign buntry)
	and show	ō	10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
	Mary 28a-f otifie	Funeral Director	MD CHARLES	LA	PLATA					1 🏋 Yes 2 □ No
	th the	a D	10e. Street and Number			10f. Zip Code	_		10g. Citizen of What C	•
	ms 2	nue	10200 LA PLATA		2 40 1	2064			U. S. 7	
21215-0036	filed within 72 hours after death with the Maryland ital Hygiene. Set on them some of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	β	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>Yes 2 X No If Yes, Give Year or Dates.</li> </ol>		/as Decedent of His Yes, specify Cuban ☐ Yes 2  ☑ No		Rican, etc.)	14. Race - Ame Black, White Specify: Wil	
15-(	72 hou "nat edica	ple	15. Decedent's Educ (Specify only highest grade		(Give k	ent's Usual Occupat ind of work done du		na	16b. Kind of Business	/Industry
12	ithin 7 ene. than he M	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)				
d 2	filed within al Hygiene. d other tha	Be	17. Father's Name (First, Middle, Last)		HOMEM		18. Mother's Nam	(First Middle I	OWN HOME  Maiden Surname)	
Maryland	should be file n and Mental I 7 is marked c raumatic eve	P.	LEVI JEFF LITT	LE					HOLMES	
lan	2 should be th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	Address (Street an	d Number or Rura	l Route Number,	City or Town, State, Zi	o Code)
	1 and 2 soft Health item 27 other tra		BOBBY E. RUSSELI	·			R LN.,W	ALDORF	,MD 2060	L
Baltimore,	Page 1 ament of Hant: If ite		20a. Method of Disposition  X⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		ition (Name of atory or other place) IETERY		-2012	20c. Location - City or CRUCIFER	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	C.	22.	Name and Address	of Facility RAY	MOND F	UNL.SERV	ICE, P.A.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the death						Approximate
and.	Physician/		Immediate Cause (Final disease or condition		Janc	ed D	emen	tia.		Interval Between Onset and Death
, J.	Medical Examiner		resulting in death)  Sequentially list conditions, b.	Due to (or as a consequ	ence of m	ed Di	Ciency			
	p ii	Examine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	15 Uh	2110			
	ate be executed hysician and the burial-transit	Exan	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence	lure	00	SICCE			
0	be ex sician buria	dical E	rooding in doubly Edot	240 10 (01 40 4 00113694	erice ory.					
2092	icate p physis the	ledi	d.,							
. Box 687	To the Hospital or Attending Physician: The law lequires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificat. has been signed by the attending physician and completely filled in by the funeral director, p. ge 2 should be detached for use as the burial-transic.	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	If yes, outcome of pregnar  1  Live Birth 2 Fetal  4  Pregnant at time of de  9  Unknown	death 3 🗌	Ectopic pregnancy Other (s <i>pecify</i> )			23d. Date of de Month	ivery Day Year
Division of Vital Records, P.O.	res that the dea signed by the a d be detached f	Completed by P	Part II. Other significant conditions contri Dichetos me Lui	buting to death but not resu	Ilting in the un	derlying cause given	n in Part I.	1	pacco use contribute to	the cause of death?
buc	requires teen signal	lete	Hynoblipider	tin, Hype nia, Arthi	44			24a. Was ar		opsy findings available
ec	sician: The law certificat has birector, pcge 2 s	E O	The real	1 0 11 0	177			autops perforr	prior to death?	completion of cause of
alF	ian: T		25. Was case referred to medical			26. Place	e of Death (Check		2 No 1 Yes	2 No
Ξ	hysic his ce	욘	examiner? 1 Yes 2 No	oital: 1 🗌 Inpatient 2 🗍 E	R/Outpatient	3 DOA Other:	4 Nursing Hor	ne 5 🗌 Reside	ence 6 Other (Speci	fy)
J Of	ing P	Certificate:	27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	,		w injury occurred	
sior	ttend death stor: /	tific	2 Accident Investigation 3 Suicide 6 Could not be	00 51 61			s 2 No			
DİXİ	tal or A rs after al Direct led in by	Sel	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, tarm, stree	t, factory, office	ľ	8f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Uneck 2 L. Medical Examiner:	n: To the best of my knowle On the basis of examination actitioner: To the best of my	and/or investig	ation, in my opinion.	death occurred at a	he time date and	d place and due to the c	ausole) and manner stated
	Vithir comp		29b. Signature and title of certifier	2000	, kilomougo, c	29c. License nu			9d. Date signed (Month	
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	400		30, Name and address of person who comp D6 J03 im V92ho			ation B	NdSte	s, Gile	nBusnie,	m0,21061
	State Registra	9	AUG 3 0 2012	32. Registrar's Signatu					· · · · · · · · · · · · · · · · · · ·	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMonth Robert Wayne Rooney Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Piata **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 214-82-7293 Country) **Director** 1 ፟M 2 □ F 52 06/07/1960 Tennessee or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Waldorf 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 20602 United States 1004 Dartmouth Rd. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ Black, White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates. Retired and Mental Hygiene.
is marked other than "natun
aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retired MSGT/E7 U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James R. Rooney Barbara Binkley Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 street of Health a Elena Fedotova/Spouse 1004 Dartmouth Rd., Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) MD Veteran Ceme. 08/29/12 Donation 5 Other (Specify) Cheltenham, MD 22. Name and Address of Facility Raymond Funeral Svc., P.A. 21. Si a ature of Funeral Service Lice MO1517 5635 Washington Ave. La 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumoni disease or condition resulting in death) to (or as a consequence of): Medical Examiner una Can cus Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Exami sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical death certificate be P.O. Box 68760 for use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗷 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No after death.

Director: After this certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ Other: MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pr ditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 21,2012 of person who completed cause of death (Item 23a) (Type, Print) 1. Date filed (Month, Day, 1) AUG 3 0 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 16 Pay 2012 ear Donald Alexander Ross 5:00A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Larkin Chase Prince George's Bowie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours 1 ▼M 2 □ F 227-32-5746 Min. 82 N&V:"30", 1929 Hawari Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's New Carrollton 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8203 Oliver Street 20784 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 N Yes 2 No
If Yes, Give 1953-1955
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than '
traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Computer Analyst Federal Govnt. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ian Hamilton Ross Juanita Morrow permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann C. Ross -wife 8302 Oliver Street New Carrollton, Maryland 20784 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Metropolitan Crematory 8/17/2012 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Bonald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Marvland20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Lung Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure; Pulmonary Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45217 August 17, 2012 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adebowale Ajayi, M.D. 6201 Greenbelt Road, #M-18 College Park, Maryland 20740

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ AUGUST 10, PATRICIA MILLER SOOD 3:45 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPICE OF QUEEN ANNE'S, INC. **OUEEN ANNE'S** CENTREVILLE 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours 07/13/1935 NEW JERSEY Director 002-26-4661 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND KENT CHESTERTOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7804 COUNTRY CLUB LANE 21620 UNITED STATES 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 **TEACHER EDUCATION** 4 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EUGENE PORCH MILLER OLIVE DAVIDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl tment of Health a tant: If item 27 is jury or other tra 2877 PEBBLE BEACH DR. ELLICOTT CITY, MD 21042 CINDY SCRUGGS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAEPAKE CREMATION 08/10/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licens 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Kick 23a. Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final ADRENAL Onset and Death CARCINOMA WITH BONE METASTASES Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 nding p use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atter in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe certificate 2 No 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\cancel{\textbf{X}}$  Other (Specify) Hospital: 1 Yes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No in 24 hours after death.

Reference of the Funeral Director: A pleted filled in by the funeral pleted filled in by the funeral pleter. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 ho

To the Fune

completed fi

State Registrar DHMH 17 Rev 7/2009

m5

(Check

only one)

3 [

Name and address of person who

29b. Signature and title of certifie

of death (Item 23a) (Type, Print)

strar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0041587

rtown, MD 21020

29d, Date signed (Month, Day, Year

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08/15/2012 EDMORE MOORE STATON, JR. 1500 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hosptial Cheverly Prince George's Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours (Month, Day, Year) 578-20-2804 Usual Residence of Decedent **Director** 1 X M 2 □ F NC 06/15/1925 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director notified 28a-f Prince George's Riverdale 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral USA 20737 6216 Carters Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates 1943 – 1945 þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Construction Worker Ith and Mental Hygier 27 is marked other to traumatic event, the 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillie Mae Plummer Edmore Staton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6216 Carters Lane, Riverdale, MD 20737 27 Josephine Staton/wife Department of Health Important: If item 2 any injury or other t other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 8/20/2012 Cheltenham Veterans Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or Injury that initiated events resulting in death) Last and attending physician Physician/Medical the bu Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal Geal Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 3 Probably 4 Unknown No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autops perform this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \sum Yes Other: ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manyer as stated only one) 29b. Signature and fitte 29c. License number 29d. Date signed Month. 30. Name and addre oleted cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aŭgust 2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 coston If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Country) Director 066-30-8285 1 🗆 M 2 💢 NEW YORK 07/09/1937 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic eve it, the Medical Examinar must be netified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No KENT MARYLAND ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 6002 LAWTON AVENUE 21661 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. 3X Widowed 4 ☐ Divorced Specify: Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 INNKEEPER HOSPITALITY Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RALPH BOARDMAN ROSE CALIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROB SANTANGELO / SON 6002 LAWTON AVENUE ROCK HALL, MARYLAND 21661 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 08/15/2012 STEVENSVILLE, MARYLAND . Signature of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 23a. Part 1. Enter the discase, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Se Physician/ p+ic 5hock disease or condition resulting in death) Medical Due to (or as a consequence of) Examine ective Aorti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transi Stage or Attending Physician: The law requires that the death certificate be executed 15cl that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Stage Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical 8 26. Place of Death (Check only one) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital of within 24 hours at To the Funeral D completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and or in a 3 Certifying Nurse Practitioner: To the best of my knowledge. only one med at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, MD *D*ヲ2*893* 2012 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18,5 washington st, Easton, MD 21601 Chernet Teklemichael 31. Date filed (Month, Day, Year) 32. sistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ond hn 1:20 A M August 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Center Waldorf Genesis Waldorf If Under 1 Year Social Security Numbe If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 02/24/1923 Country)
Wisconsin 1 X M 2 1 89 Director 72-18-8375 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20603 2714 Sun Valley Dr 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes, 2 □ No If Yes, Give Year or Dates. 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 🔀 Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural". Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sgt. E-7 the U.S. Air Force Ret. Master Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Raymond Sundberg Agnes Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1754 Beverly Ct., Frederick, MD 21701 John R. Sundberg, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) MDVeteran Ceme. 08/28/12 Cheltenham, 22. Name and Address of Facility Raymond Funeral Svc., 21. Si natur of Funeral Service Licen MD 20646 **M**10 1517 5635 Washington Ave., La Plata, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Jemenna HC Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine nouse Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 2 No Unknown 9 Unknown been signed by . Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending after death. 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 7/2009 Ur. Joslin Vazhovop

Name and address of person who completed cause of death (Item 23a) (Type, Print) oution Blud SteB, Gilen Busnu, mD, 2106)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Constance Strasberger Eugenia 03:59 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Airy Kline Hospice House 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign April 1933 Days Min. 79 Mary Yand 214-28-0866 Director 1 🗆 M 2 🕮 F Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD Frederick Braddock Heights 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6922 Potomac Avenue 21714 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event; the Magnes. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Madeline Harshman Charles James Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Strasberger 6922 Potomac Ave., Braddock Heights, MD 21714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Zion Lutheran Cem. 8/27/2012 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Keeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, Maryland 21701 MO1612 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic un Known Primary disease or condition m Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burlal-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an is certificate has director, page 2: autopsy Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospice Hous 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 4 hours after death. uneral Director: Aft ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) the Street 30. Name and address of person , Frederick, MD 2170

State

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

Eskander

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 9:00A. Gertrude Sussman August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Atrium Assisted Living Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days 1 M 2 SF Hours 098-24-1379 97 Sept. 18,1914 New York Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 913 Burnt Crest Lane 20903 United States ortant; If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, Completed by 1 Never Married 2 Married 1 Yes : White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager medical should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sophie Saperstein ည (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Ivan Sussman -son 913 Burnt Crest Lane SilverSpring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beth Israel Cemetery |8/19/2012 4 Donation 5 Other (Specify) Woodbridge, New Jersey 21. Signature of Funeral Service Licenses Bohald WesBorgwardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** vears Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Live Grant Ectopic pregnancy Day ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 AN 1 ☐ Yes 2 🛣 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Assisted Livin) Manner of Death 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending s after death.

I Director; Aft
d in by the fur 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D17874 August 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sankaran M. Nayar, M.D. 3717 38th Avenue Cottage City, Maryland 20722

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

AUG 3 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vanetta Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Director** Apr 23, 1941 <u> 232-62-6395</u> 1 🗆 M 2 🛛 F 71 ms 23a or 28a-f show must be notified at 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 427 Beall Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed white Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) laborer General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Margaret Williams Donald Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 427 Beall Street Cumberland Zip Code) 21502 John Vanetta husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 1 Durial 2 Kremation 3 Demoval from State 8/24/2012 Cresaptown MD Donation 5 Signature of Funera Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. If yer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause \_\_ each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition MONOUR Medical resulting in death) Due to lor as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sensequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 2 12 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 **N**O Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 24 hours after death.

e Funeral Director; A pletely filled in by the fu Accident 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Ur. Christophis Has Interventional Conticle WMHS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haas D.O. 12502 Willhobrook Rd. Str. 330 ( Registrar

DHMH 17 Rev 06-2011

1. Decedent's Name (First, Middle, Last)

ı	Physicia Medic		1. Decedent's Name (First, Middle, Last Louise Ma	orie Whitlo	o₩			2. Date of De	eath Day	3. Time of Death
0	Examir		4a. Facility Name (if not institution, give s Doctor's Commu	street and number) Inity Hospita	al	4b. City, Town, o Lanh	r Location of De	- 4	4c. County	y of Death nce Georges
	Funeral Director		5. Social Security Number 224-58-8228  Usual Residence of Decedent	× 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M		ay, Year)	g. Birthplace (State or Foreign Country) Virginia
	faryland 8a-f show tified at	ector	10a. State 10b. County Md. Prince		Town or Loc istri	ation Lct Hei	ghts			10d. Inside City Limits 12 Yes 2 □ No
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 1932 Rochelle	Avenue #10	34	10f. Zip Code 207	47		10g. Citizen of U . S	•
036	/2 hours after death with the Maryland n "natural", or items 23a or 28a-f sho edical Examiner must be notified at	by	11. Marital Status  1   Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If	/as Decedent of H Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Bla	ce - American Indian, ick, White, etc. :: Black
Baltimore, Maryland 21215-0036	hin 7 ne. <b>than</b>	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th		(Give ki life. DC	ent's Usual Occup ind of work done of NOT use retired)	during most of v	vorking		Business/Industry  Capitol
land ?	should be filed wit and Mental Hygie is marked other aumatic event, th	To Be	17. Father's Name (First, Middle, Last) Daniel Whitlo				18. Mother's Flor	Name (First, Middle, Cence Da	vis	
, Man	and 2 should Health and N tem 27 is me other trauma		19a. Informant's Name/Relationship (Tyx Renee Simpki	<sup>ne, Prin</sup> (Daughter ns	19b. Mailing	g Address (Street Charte	and Number or	Rural Route Numbe	er, City or Town, S #2D As	Shite Zio Code) Shi and Va. 23005
imore	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State Wasi	ce of Dispos netery, crem ningt	sition (Name of atory or other place Nationa	e) 108,	Date / 15/12		- City or Town, State and , Md •
Balt	permit. Depart Import any inj		21. Signature of Fureral Ser ice License	CC0530	22. L 3	Name and Address atney s 831 Geo	s fune; Fune; orgia	al Home		20011 nington, DC
	Pnysician/ Medical		23a. Part 1. Enter the disease, o compi shock, or heart failure. Listonly on Immediate Cause (Final disease or condition resulting in death)	a Houte	The	the mode of dyin	g, such as card	ac or respiratory ar		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent of the consequent of	nce of):		ه کار			
	executed an and inal-fransit	sian/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequen	nce of):	-1 Q1V	6 (	LUT .	MYOPA	They
09289	th certificate be execute trending physician and for use as the burlar trans	Medica	IF FEMALE:	d	LIAZ		1 13141		117,	
. Box 6			23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	33c. If yes, outcome of pregnance 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea g ☐ Unknown	death 3 🗌	Ectopic pregnand Other (specify)	sy			ate of delivery onth Day Year
ds, P.O.	requires that the der been signed by the s should be detached	ed by Pi	Part II. Other significant conditions con	ntributing to death but not result	ing in the un	derlying cause giv	en in Part I.	23e. Did t		tribute to the cause of death?
Division of Vital Records,	ysician: The law rec is certificate has bee director, page 2 sho	Completed by Physi							psy ormed?/	Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
Vital	ysician: nis certific I director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital:	R/Outpatient	Oth	ace of Death (Coer: 4  Nursing	heck only one)	dence 6 🗆 Othe	er (Specify)
ion of	terding Ph ecth. or After thi th_funeral	ificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	8b. Time of injury	28c. Injury work M 1 □	/ at ? Yes 2 □ No	. 28d. Describe f	now injury occurr	ed
Divis	To the Hospital or Attending I within 24 hours effer death.  To the Funeral Cirector Affer Completely filled in by the funeral Cirector.	Medical Certificate:	4 Homicide determined	building, etc. (Specify)				City or Tov	vn, State)	er or Rural Route Number,
	the Hosp hin 24 ho the Fune npletely 1		(Check 2 Medical Examin only one) 3 Certifying Nurse	cian: To the best of my knowled ler: On the basis of examination a Practitioner: To the best of my	nd/or investi	gation, in my opinic death occurred at t	on, death occurre he time, date an	ed at the time, date a	and place, and du	e to the cause(s) and manner state
	2 2 4 4 5		29b. Signature and title of certifier	Ju >		29c. License	number 6 2 8 / 1	0	29d. Date signer	d (Month, Day, Year)
				1 011-0	3a) (Type, Pri			LANHA	m, md	20706
	Stat		31. Date filed (Matturgy, Year) 201	2 32 Registrar's Signatu	ba	Kind	•		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Department of Health and Men Certificate of Death		2012	27926
			1. Decedent's Name (First, Middle, Last) 2. [	Reg. Date of Death	NoZ U I Z	3. Time of Death
ı	Physicia Medi			Month C	Day 2° 12	09:19 AM
The same of the sa	Examir	ner	(hart 2)		4c. County of Death	
70	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8, 0	Date of Birth	ne/IT	place (State or Foreign
	Director		218-34-2567 1 $\square$ M 2 $\mathbf{X}$ F Yrs Months Days Hours Min.	Month, Day, Yea	ar) Coun	try)
	nd show at	ا اة		0/03/193		LAND  Od. Inside City Limits
	Maryla 88a-f s	rect	MARYLAND KENT CHESTERTOWN			1 <b>X</b> Yes 2 □ No
	h the	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	. Citizen of What Cour	try?
	ath will	uner	212 DAVID DRIVE 21620 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Y		ITED STATE	
9	er dez or ite miner	by F	1 Never Married 2 Married 1 Types 3 Types	yes or No- n, etc.)	14. Race - Americ Black, White,	
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at				Specify: WHI	TE .
15-	72 ho in "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b	o. Kind of Business/Ind	dustry
212	within giene. er tha t, the N			E	DUCATION	
Maryland	ild be filed Mental Hy, iarked oth atic event	To Be	le l		,	
ž	2 should be fil Ith and Mental 27 is marked 27 is marked 1 traumatic ev		EDWARD ARTHUR TASCHENDERGER STELLA VIRG			
	d 2 sh alth ar 27 is er trau				or Town, State, Zip C IARYLAND 2	
ore,	ge 1 and 2 It of Healt If item 2 or other		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)		. Location - City or To	
Baltimore,	Pag ant:		4 Donation 5 Other (Specify)  DAVIS MEMORIAL CEMETERY 08/13	3/12 CU	JMBERLAND,	MARYLAND
Bal	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee  FELLOWS, HELFENBEIN & 130 SPEER ROAD CHESTE	NEWNAM	1 FUNERAL 1	HOME, P.A.
			23a. Part 1. Enter the disease, a completions that caused the death. Do not enter the mode of dying, such as cardiac or responds, or heart failure. List only one cause in each line.	piratory arrest,		Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death
1	Examiner		Due to r as a consequence of):			
	THE REAL PROPERTY.	iner	Sequentially list conditions, if any, leading to immediate it any, leading to immediate but to (or as a consequence of):			
	cuted ind transit	Examine	Cause (usease or injury that initiated events c			
	ate be executed hysician and the burial-transit	dical E	ப் resulting in death) Last Due to (or as a consequence of):			
<u></u>	ficate I g phys as the	/ledic	d			
× 687	h certi tending r use	an/N	F FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1		23d. Date of delive	ry
Box	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Of the Funeara Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	1   Yes 2   No 9   Unknown 9   Unknown		Month	Day Year
P.0	s that t gned b be deta	by P	Part Unother significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	
Division of Vital Records,	requires been sig should b	Completed by		1 Yes	2 No 3 Prob	ably 4 🗆 Unknown
eco	e law ı e has b ge 2 s	du	E HIMO SISUACION	24a. Was an autopsy performed?	prior to con	sy findings available opletion of cause of
<u>E</u>	an: Th tificate tor, pa	Be Co		1 Yes 2		2 <b>X</b> No
Zi Zi	hysici his cer al direc	은	P 1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5		6 ☐ Other (Specify)	
J of	ling Pl .r After th funera			Describe how inj		
Siol	Attenc r death ctor.	Certificate:	2	ocation (Street	and Number or Rural I	Pouto Number
Divi	tal or safter sa affer all Dire			City or Town, Sta		Toute Number,
	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check Check e date and place	ice and due to the caus	ca(e) and manner stated	
	To the vithin to the comple		only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and 29b. Signature and title of certifier 29c. License number	nd due to the cau	use(s) and manner as st Date signed (Month), D	ated.
	10		1027 MD D71027	C	3/08/-	2012
		İ	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	ch.t.	- No	2/5-
	Stat	e	e 31. Date filed (Month Daryear) 2012 32. Registrar's Signature	Weste	Nown M	121620
	Registra		a St. Date filed (NOTA) 2012 32. A gistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician BERNICE R. WAGNER  BERNICE R. WAGNER  BERNICE R. WAGNER  4. Solv, Town, or Location of Death SANCTUARY AT HOLY CROSS  BURTORS VILLE  4. Solv, Town, or Location of Death SANCTUARY AT HOLY CROSS  BURTORS VILLE  4. Solv, Town, or Location of Death MONTCORPER  5. Solve Security Principles of Seas of Seas of Security Principles of Seas of Security Principles of Seas of Security Principles of Seas of Security Principles of Seas of Seas of Security Principles of Sea				For State State Registrar	ate of Maryland	•	artment of H		_	giene Reg. No. 2	n 1 2	2792
Sharp of the control				Decedent's Name (First, Middle, Last)					2. Date of De	ath	2012	3. Time of Death 9:00A M
Barrier   Barr										4c. Count	y of Death	
The Same   The Country   The			0.	183-18-6249 <sup>1□ M 2</sup>					8. Date of Bird (Month, Da	th 50,1923	9. Birthp Count	Penna.
The Bord   2   Organism on 3   Remove throughout the properties of the country	yland	od at	ctor	10a. State 10b. County							10	Od. Inside City Limits
The Bord   2   Organism on 3   Remove throughout the properties of the country	the Mar	a or 28a be notifi	I Dire	10e. Street and Number		Tullible	10f. Zip Code	· • • • • • • • • • • • • • • • • • • •		-	What Coun	
The Bord   2   Organism on 3   Remove throughout the properties of the country	eath with	tems 23 er must	Funera	11. Marital Status 12. Wa		13. V			cify Yes or No-	14. Ra		
The Bord   2   Organism on 3   Remove throughout the properties of the country	USO rs after d	ral", or i Examin	by	1 Never Married 2 Married 1	☐ Yes 2 😾 No ∕es, Give				nican, etc.)			
The Bord   2   Organism on 3   Remove throughout the properties of the country	<b>2   3-U</b> n 72 hou	e. an "natu Medical	mplet	(Specify only highest grade con	pleted)	(Give k	and of work done du		ng			
The Bord   2   Organism on 3   Remove throughout the properties of the country	IQ Z I.	Il Hygiene other th	Be	12 17. Father's Name (First, Middle, Last)		C1e	erk	18. Mother's Name	e (First, Middle,			ers ————
The Bord   2   Organism on 3   Remove throughout the properties of the country	arylar ould be f	nd Menta marked imatic e	To		nt)	19b Mailin	a Address (Street a		-		State. Zio C	ode)
The Bord   2   Organism on 3   Remove throughout the properties of the country	e, Ma and 2 sh	Health a		Jerry L. Wagner/ S	on	647	7 S. Wind	d Circle	Co1u	ımbia, N	1D	21044
State   Stat	t. Page 1	tment of tant: If it jury or o		1 🕅 Burial 2 □ Cremation 3 🖼 Remove 4 □ Donation 5 □ Other (Specify)	ral from State Geis	metery, crem sey Me	emorial Ce	em. Aug.	I		•	
Shock, or heart failure. List only one cause on each line.    Immediate Cause (Final Final Legal Content on the Cause of Part III) Cause (Pinal Legal Content on the Cause of Part III) Cause (	<b>Dal</b>	Depar Impor any in once.		21. Signature of uneral Service Licensee	#CC0265	5	. Name and Address	s of Facility	~			
Due to (or so a consequence of):   Advanced dementia   Due to (or so a consequence of):   Advanced dementia   Due to (or so a consequence of):   Advanced dementia   Due to (or so a consequence of):   Advanced dementia   Due to (or so a consequence of):   Consider the property of the	Phy	vici n/	9 0	shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.		, ,	, such as cardiac c	r respiratory an	rest,		Approximate Interval Between Onset and Death
Due to (or as a consequence of):    Consequence of the sequence  1.	Medical		a	Due to (or as a conseque	nce of):							
Female:   23d. Use decedent pregnant   23d. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   23d. Date of delivery	pe	sit	miner	if any, leading to immediate cause. Enter Underlying								-
Female:   23d. Use decedent pregnant   23d. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   23d. Date of delivery	e execut	cian and ourial-trar	al Exa	that initiated events C. —	Due to (or as a conseque	nce of):						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	oo / oo rtificate b	ing physi e as the k	/Medic	IF FEMALE:						1		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	. <b>DOX</b> O	/ the attend ched for us	ysician	in the past 12 months? 1 ☐ Yes 2 ☐ No	Live Birth 2 🗀 Fetal o	death 3						*
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	S, T.C	signed by	by	_		-	nderlying cause give	en in Part I.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	COLOR law requi	as been 2 should	nplete						autop	osy	prior to con	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	an: The	rtificate h		evaminer?			26. Pla	ce of Death (Check	1 Yes			2 🗆 No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	OT VIT	er this ce eral direc	은	1 Yes 2 X No  27. Manner of Death  28.	1 ☐ Inpatient 2 ☐ E a. Date of injury 2	8b. Time of	t 3 🗆 DOA   28c. Injury	4x x Nursing Ho				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	SION	death. ctor: Afte y the fun	rtificat	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆 Y	res 2 No	28f. Location (S	Street and Numi	ber or Rural i	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	pital or /	ours after eral Dire filled in b		4 - Nomicide determined	building, etc. (Specify)				City or Tow	n, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli MD 9801 Georgia Avenue Suite 1-17 Silver Spring, MD 2090  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	the Hos	thin 24 he the Fun mpleted	Medi	(Check 2 ☐ Medical Examiner: On only one) 3 ☐ Certifying Nurse Prac	the basis of examination a	and/or invest	igation, in my opinior leath occurred at the	n, death occurred at time, date and plac	the time, date a e, and due to the	nd place, and d e cause(s) and n	ue to the cau nanner as sta	se(s) and manner stated ted.
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	٩	1										
State		Ø		Sunitha Bhogavilli	MD 9801 C	Georgi	a Avenue	Suite 1	-17 S	ilver S	pring	,MD 20902
THE RESERVE TO AND THE PARTY OF							w					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Fasure All Capies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Charles Aaron Weddle 1:25 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGINES HOSPITAL Baltimore County BALTIMORE MO Social Security Number **Funeral** Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □XM 2 □ F 185-20-7710 Months (Month, Day, Year) Hours Min. **Director** 85 Wayneshoro Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel 1 X Yes 2 No Pasadena 10e. Street and Number ō 10f. Zip Code "natural", or items 23a o 10g. Citizen of What Country? Funeral 8394 Country Life Road 21122 US 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Xyes 2 No
If Yes, Give 1941-1945
Year or Dates. 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 721 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha telecommunications cort. <u>engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be Joseph G. Weddle, Sr. Mae E. Newcomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jeanie Lloyd 1177 Delmont Rd. Severn, MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cem. July 15, 2012 Waynesboro, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PA 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIO PULMO:NAPT disease or condition STRQLIST Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA, ASPIRATION DAYS Sequentially list conditions Examine Sequentially list conducting, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events assisting in death) I ast Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed DEMENTIA YEARS Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) \_\_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, Completed 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate has performed? Yes 2 X No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death ë 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certificat injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier

State Registrar

HARLES

EDDLE

S CATON

32. Registrar Signature

DTITA

BALTIMONZE

AVE,

MI

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATLA

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

August 20, 2012

21220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#7perFH, G932, 10/15/2012, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:25 PM اندار 2-0)2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death County of Death alh Cit Maye more 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 1 M 2 DF 7 23 0 Mary Usual Residence of Decedent show 10a. State 10b. County the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified hestertown 28a-f 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral Baywood 2162 SA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) . Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) artment of Health and Mental Hygie sortant: If item 27 is marked other injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ilson.dr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilson-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/3/12 4 ☐ Donation 5 ☐ Other (Specify) WORTON permit. Hellenbein + Newman Funeral Home er Road Chestertoon MD 211020 Des art Import any inj once. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c s hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ischemic Encephalopath OXIC disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 帯∫ Division of Vital Records, P.O. Box 68760 ass IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ detached for in the past 12 months? Pregnant at time of death Month Dav Year 2 No the 9 Unknown Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 🗌 No Yes 2 No 1 Tes Physician: 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital 2XNo Other: 1 Yes ည 24 hours after death.

Funeral Director: After this one of filled in by the funeral director. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 🗌 Yes Certificate: 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending 2 Accident M 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce MD 24,2012 S 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) MD St. Baltimore tobbs Janice 1800 Orleans 31. Date filed (Month) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29 Day 2012 Year Frances Wolff Abzug 6:09 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maplewood Park Place Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours July 13, Year 1916 Director 086-09-2710 NewTork 96 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9707 Old Georgetown Road 20814 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: Whi<u>te</u> 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H မှ Henry Wolff Emma Weiss permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Abzug (Son) 3504 Cactus Wren Way., Austin, TX 78746 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Wellwood Cemetery 9/2/2012 4 Onation 5 Other (Specify) Pinelawn, NY 21. Sign rure of Fur eral Service Lice 22. Name and Address of Facility Metropolitan Funeral Service any 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Severe Dementia Sequentially list conditions, if any lacuse. Enter Underlying Cause (Disease or linjury Examiner Dire to for as a consection of of or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month 1 Yes 2 L 9 Unknown detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available cate has page 2 s autopsy prior to completion of cause of death? performed? this certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific AUG 29, 2012 100

State

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WENDY Wang deSilva, CRNP 77

7758 WISCONSIN AVE #211 BETHESDAY MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, 1 ast) 2. Date of Death Physician/ Month Khalil Aruna August 16 2012 12:40AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 408 Torrington Place Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 578-86-6317 1 X M 2 □ F Yrs. 62 Dec. 10, 1949 Seirra Leone show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Torrington Place 20901 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married Completed by 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Abdul Aruna Asiatukona Aruna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Aminata Wai Aruna/Wife</u> 408 Torrington Place Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or or 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Freetowne, Sierra Leone 4 ☐ Donation 5 ☐ Other (Specify) 9/16/2012 Family Plot 22. Name and Address of Facility J.E. Jenkins Funeral Home, Inc. Signature Funeral Service Licens ee 7474 Landover Rd Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pancreatic Cancer 6months Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Dav Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown certificate has been si lirector, page 2 should Paroxysmal Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: ည 1 🗌 Yes 2 **X**No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours within 2 To the F

State Registrar

DHMH 17 Rev 06-2011

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert H. Gerard, MD 1500 Forest Glen Rd. Silver Spring, MD 20910

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0055522

29d. Date signed (Month, Day, Year)

August 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ August 28 Day 2012 Year 7:35 Рм Pingley Abbot Gray Neva Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6908 Sulky Lane Rockville Montgomery 5. Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth (Month, Day, Year) Hours Min. Director 233-26-8735 1 🗆 M 2 💢 F 92 January 16, 1920 West Virginia Usual Residence of Deceden r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 X Yes 2 □ No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6908 Sulky Lane 20852 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 💢 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates. 1942–1945 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Pingley Margaret Caplinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Chapala Drive, Pacific Palisades, California 90272 Brenda Abbot Anderson/Daughter 20b. Place of Disposition (Name of cemetary, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 30, 1 Burial 2 D Cremation 3 Removal from State August injury 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Tuneral Home/Bethesda-Chevy Chase, Atri John 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) <u>Alzheimer's Dementia</u> Years Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial Physician/Medical P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🔯 No this certificate 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \) \( \text{X} \) Residence 6 \( \subseteq \text{ Other (Specify)} \) Hospital: ၉ 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hou To the Fune completely fi only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 4000 D33443 August 29, 2012

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 4 2012

Alan R. Pollack, M.D. 1201 Seven Locks Road #111, Rockville, Maryland 20854-2957

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

GOOD SAMARITAN HOS PITAL  S. Sould Security Number  1. S. Sould Security Number  2. S. Sould Security Number  2. S. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  2. Sould Security Number  3. Sould Security Number  2. Sould Security Number  3. Sould Security Number  2. Sould Security Number  3. Sould Security Number  2. Sould Security Number  3. Sould		
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GOOD SAMPARITAN HOS PITAL  S. SUM Security Number  213—58—1810  10 Number  213—58—1810  10 Number  213—58—1810  10 Number  10 Corry  10	punty of Death	
Director    213-58-1810   10 M 2   E   60   Vrs.   Words   Days   Hours   Min.   01/18/1952   10. State   10. County   10. City, Town or Location   Baltimore   10. State   10. County   10. City, Town or Location   Baltimore   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. County   10. City   10. State   10. City   10. State   10. City   10. State   10. City   10. State   10. City   10. State   10. City   10. State   10. City   10. State   10. City   10. State   10. State   10. City   10. State   10.		
The control of the	<ol> <li>Birthplace (State or Foreign Country)</li> </ol>	n
September   Sept	2 Maryland	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause. Final disease or condition resulting in death)  Part of the standard of the st	10d. Inside City Limits	
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause. Final disease or condition resulting in death)  Part of the first	tion - City or Town, State NSVille, MD.	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate cause. Final disease or condition resulting in death)  Part of the first		_
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disagner or Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disagner or Part II. Other significant conditions cause)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disagner or Injury that initiated events resulting in death)  Due to (or as a consequence of):  ASPIRATION PNOMONIA  Due to (or as a consequence of):  ASPIRATION PNOMONIA  The Birth 2   Fetal death   2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   5   Other (specify)    John 25   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No   1	Approximate	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury at No. 1 and 1	Interval Between Onset and Death	
Due to (or as a consequence of):	is days	
FEMALE:   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 5   Other (specify)   1   Yes 2   No   1   Yes 2   No   1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 3   Yes 3   Yes 4   Yes 2   Yes 3   Yes 4   Yes 2   Yes 4   Yes 2   Yes 3   Yes 4   Yes 2   Yes 4   Yes 2   Yes 3   Yes 4   Yes 2   Yes 3   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 4   Yes 5   Yes 4   Yes 5   Yes 4   Yes 5	dance	
FEMALE:   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Fetal death   3   Ectopic pregnancy   1   Live Birth 2   Environment   1   Live Birth 2   Live Birth 2   Environment   1   Live Birth 2   Live Birth 2   Live Birth 2   Environment   1   Live Birth 2   Live Birth 2   Live Birth 2   Live Birth 2   Live Birth 2   Live Birth	couys	
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Live Birth 2   Endown 2   Live Birth 2   Live Birth 2   Live Birth 2   Live Birth 2   Endown 2   Live Birth 2   Live B		
23b. Was decedent pregnant in the past 12 months?   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 3   Yes 4   Yes 2   Yes 4   Yes 3   Yes 4		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use conditions to the property of the	d. Date of delivery Month Day Year	
Property of the property of th	contribute to the cause of death?  No 3 □ Probably 4 □ Unknow	
A coldent of location (Street and Nurm street, factory, office 28f. Location (Street and Nurm street, factory, office 28f	24b. Were autopsy findings available	
25. Was case referred to medical examiner?  1	prior to completion of cause of death?  1  Yes 2 No	
1 Impatient 2 ER/Outpatient 3 DCA		
1 Natural   5 Pending   1 Notice   1 Notic		
28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Num		
building, etc. (Specify)  City or Town, State)	umber or Rural Route Number,	
2 Accident investigation of the building, etc. (Specify)  28f. Location (Street and Num City or Town, State)  28f. Location (Street and Num City or Town, State)  28g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28g. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and material control only one) 3 Certifier 1 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and material control only one) 3 Certifier 29d. Date sign	id due to the cause(s) and manner stat	ted.
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	igned (Month, Day, Year)	_
B NUTAN MD RESOUD 8-2	11-12	_
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NUTAN, GOOD SAMARITAN HOSPITAL, LOCH RAVEN BOULEVARD, BALTII	TMORE MD.	
State SEP 0 4 2012 32. Registrar's Signature A. Acceptable 1. September 1. Septembe		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BAKER **GEORGE** PATRICK AUGUST 8:00 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MANOR CARE ROSSVILLE ROSEDALE Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Months Days 9 - 11 - 1930 214-26-4095 MARYLAND **Director** 81 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified MIDDLE RIVER 1 ☐ Yes 2X No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a or Funeral 21220 U.S.A. 9753 BIRD RIVER ROAD permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: WHITE Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MACHINIST THOMPSON STEEL 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ CHRISTOPHER BAKER **ERMA** KTSH J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2510 GLADSTONE COURT BEL AIR, 21015 GEORGE C. BAKER/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20c. Location - City or Town, State ☼ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-31-12 DULANEY VALLEY TIMONIUM, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funer Servi e Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final We Phylician disease or condition resulting in death) Medical Due to (or as a consequer Cancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 🗌 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No after death Accident Investigation Suicide Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours af the Funeral Di mpleted filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

4

who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State C	ii iviai yiai			e of Deat			,	2010	07005
15.		Registrar  1. Decedent's Name	e (First, Middle, L	ast)		06	uncan	or Dear		2. Date of Dea	Reg. No.	<del>- U   4</del>	3. Time of Death
Physicia Medic	_	Ka	thloom	Bast	and					Month	# 30	17011	12:300M
Examin		4a. Facility Name (if	not institution, g	ive street and nun	ber)		4b. City,	Town or Locat	ion of Death			ounty of Death	,
<u></u>		Forest	Hans	n N	unci no	Hom	(	atons	wille	MD, MD		Ball	more
Funeral Director		5. Social Security Nu 213–30–0973		. Sex 1 □ M 2 <b>XX</b> F	7. Age (In yrs. 78		If Under Months	Days Hou	nder 24 Hrs. Irs Min.	8. Date of Birt (Month, Day	, Year)	Cou	nplace (State or Foreign intry)
3		Usual Residence of	of Decedent	1 IVI Z. S. S. S. I		Yrs.				10/31/19	933	Mar	yland
yland •f sho ed at	ctor	10a. State	10b. County			ity, Town or Lo							10d. Inside City Limits
r 28a- notifi	Dire	Maryland 10e. Street and Num	Baltimor	е	Ca	tonsvill	10f. Zip	Codo			10 0:::	6 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1  Yes 2 <b>XX</b> No
vith th	Funeral Director	701 Edmonds		<u> </u>			101. ZIP	21228	3		rug. Citizer	n of What Cou USA	antry ?
eath v tems er mu	Fune	11. Marital Status		12. Was Dece	dent Ever in U	.S. 13.	Was Deced	ent of Hispanic	Origin? (Spe	ecify Yes or No-	14.	Race - Amer	
", or i	by	1 Never Marri		Armed Fo 1 Yes If Yes, Giv	2 <b>Y</b> YVo		1  Yes	ify Cuban, Mex <b>Y</b> V No Spe		nican, etc.)	Sn	Black, White	, etc. Inite
atural	Completed	3 <b>XX</b> Widowed	4 ☐ Divorced  15. Decedent's	Year or Da				I Occupation				of Business/I	
n 72 h an "n Medi	dm	(Specification (Speci	cify only highest	grade completed) College (1		(Give	kind of wor O NOT use	k done durina i	most of work	ing	TOD. KING	Of Business/1	ndustry
ygiene /giene /giene /giene /giene /giene	ပိ		, ,	4	4 01 01)	Soci	al Worl	ker			State	of Mary	land
e filed tal He ed otl	To Be	17. Father's Name (F Bernard San		it)					<sup>lother's Nam</sup> Na Kazmi	e (First, Middle, errozak	Maiden Sur	name)	
ould b		19a. Informant's Na		(Type Print)		10h Maili	na Addross			al Route Number	City or To	un State Zin	Codel
1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Helen M. Bu			liece					t News, V			Code/
of Hear of Hear fitem rothe		20a. Method of Disp	position	☐ Removal from	20b.	Place of Dispo	sition (Nan	ne of	1	Date	20c. Loca	tion - City or	
Page tment tant: I jury o			5 Other (Spe		Gar			A Cemeter	-:		•		Maryland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Fur	neral Service (i.jo	Insee	Vena	Res 6	2. Name an <b>500 Y</b> 01	d Address of Fa rk Road E	acilityMito Baltimor	hell-Wied e, Maryla	lefeld I Ind 212	Funeral 12	Home Inc
be e	lical Examiner	23a. Part 1. Enter it shock, or hear Immediate Cause (I disease or condition resulting in death)  Sequentially list conif any, leading to impresse. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, mediate rlying injury s	a. Due to b. Due to c.	or as a consector as	quence of):	er the mook	e or dyling, such	as Cardiac C	n respiratory an	e51,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total.	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12,r 1 ☐ Yes 2 9 ☐ Unknown	months? No		Birth 2 Te nant at time of	tal death 3	Ectopic p		to the State of the state of th		230	d. Date of deli Month	very Day Year
requires that the der been signed by the i should be detached	by	Part II. Other signif	1	7	eath but not re	sulting in the	underlying o	ause given in I	Part I.				the cause of death?
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ding Ph. h. After thi funeral	ate:	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	5 Pending		of injury th, Day, Year)	28b. Time o injury	1 2 2	8c. Injury at work? 1 Yes		28d. Describe h	ow injury oc	ccurred	
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Hospi 24 hou Funer stely fil	Medical	(Check 2	Medical Exa		sis of examination	on and/or inves	stigation, in r	ny opinion, dea	th occurred a	t the time, date a	nd place, an	d due to the c	ause(s) and manner stated.
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Σ	only one) 3 29b. Signature and		urse Practitioner	. TO THE DEST OF	my knowledge		License numb				igned (Month	
		13	e S	alame	N.D.	rf		R119	966		A	19.12	0/2012
MI		30. Name and addre	(h-	no completed caus	e of death (Ite	m 23a) (Type,	Print)	0.000	Airo	Cata	W.M.	110	MD 21990
Stat	e	31. Date filed (Monti	h, Day, Year)		egistrar's Sign	ature	- WIN	AVIN I	1021			116	100
Registra	ar	SEL A	4 2012	Clenena	B. 1	parker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 29, 2012 Jean Doreen Binkley 6:21PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 300 Lauren Hill Rd Reisterscom.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth |
Months | Days | Hours | Min. | (Month, Day, Year) |
Oct. 2, 1 Reisterstown Baltimore Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M**X**X F 214-24-4510 1928 Wisconsin Director 83 Oct. Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Reisterstown 1 Yes 2XXVo 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 300 Lauren Hill Rd. U.S.A. 21136 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes XX No Black, White, etc. Completed by Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Country Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Club Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard English Ethel Hackman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry D. Binkley/Husband 300 Lauren Hill Rd. Reisterstown, MD 21136 20a. Method of Disposition
1 ☐ Burial XX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
All Faiths
Crematory & Chapel 9/4/12 4 ☐ Donation 5 ☐ Other (Specify) Manchester, MD 21. Signature of Fundamervic Aconsec 22. Name and Address of FacilitEckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atheroschussin Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 03228 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 114 Business Center Dr Reisterstown MD 21136 Robert L Moss

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

2012

**SEP 0 4** 

32. Registrar's Signature

amend #26 State of Maryland / Department of Health and Mental Hygiene AMEND 28A Department of Death 9/14/12 TRT Beg No. For State Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 Graham Christian Boyanich 2012 1:22 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12213 Philadelphia Road <u>Kingsville</u> Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Min. Hours Months Director 119-68-7941 1 M 2 F Yrs. 37 04/21/1975 TNshow if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother treumatic event, the Medical Exemple must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐KNo MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Duffy Court 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highe est grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Computer Forensics Baltimore Co. Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Boyanich Susan Munro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Mrs. Susan Boyanich / mother Unit 102 357 Gatewater Court, Glen Burnie, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Importent: If it eny injury or o 1 Burial 25 CxCremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) tlantic Crematory 8/24/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 1701357 23a. Part 1. Eliter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ XIA disease or condition resulting in death) Medical Due to (or at a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir ettending physician and for use as the burial-transit Hospital or Attending Physician: Te law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Fecords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the ef Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Partner's 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Other (Spec M/Residence 27. Manner of Death 28a. Date of injury FD (Month, Day, Year) 28b. Time of UNKnjury ~ PM 28c. Injury at 28d. Describe how injury occurred SUBJECT HANGED 1 
Natural 5 Pending after death. 1 ☐ Yes 2 X No 2 Accident
3 Suicide
4 Homicide 21/2012 Investigation filled in by the 28f. Location (Street and Number or Rural Route Number City or Town, State) | 7 Z 3 | Ph | Cde | Ph Ch 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct Home Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the hause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Funel completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ITIM 31. Date filed (Month Day, Year) 2. Registrar's Sig State 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 33AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death N/A 1616 Belt Street Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-36-6274 Davs Hours **Director** 1 M 2 X F 73 May 2, 1939 Maryland 1 Maryland Usual Residence of Deceden 28a-f show 10a. State 10c. City, Town or Location with the Maryland be notified at 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1616 Belt Street Examiner must USA or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Shows 2. A and Mental Hygiene.
27 is marked other than "natural" are event, the Medical Ex 3 Widowed 4 X Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 0 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve ပ George Winebrenner Romaine Ferterlier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Kellie Klebe 450 E. Fort Ave., Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Sept 1, 2012 Baltimore, Maryland The Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nce disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ō Pregnant at time of death 5 Other (specify) Month Day Year g Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Ves filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 욘 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural iniury 5 Pending Investigation Accident Μ 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completed cause of

State

Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia С. Bender August 2012 7:01 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 212 Hickory Point Road Anne Arundel Pasadena 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Hours Months Director 214-30-5075 1 □ M 2 🗓 F June 3, 1932 Maryland 80 28a-f show of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21122 212 Hickory Point Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Northrop Grumman Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of t. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked of ပ O'Connor William Α. Affeldt Aileen 19a. Informant's Name/Relationship (Type, Print) 212 Hickory Point Road Pasadena, Maryland 21122 Deborah L. Taylor (Daughter) 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or or once. cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 08/27/2012 Atlantic Cremation Glen Burnie, Maryland 21. Signature of Fineral Service Licenses MOO-732 MacCully-Polyniak Funeral Home Pyland 21122 23a. Dert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ wolan disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atter in the past 12 months? Month Year Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 Yes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 19 No ပ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending within 24 hours after death.

To the Funeral Director Af 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

8/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Aug Physician/ Zotz ANTHONY J BROWN 14:32 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UMMC - SHOCK TRAUMA CENTER BALTIMORE, MD BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 214-64-2768 1 PM 2 DF Director 56 MD 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified Edgemere Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a must be Strebor 21219 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 12 Yes 2 \sum No AF
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 No After Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: black "natural", 3 Widowed 4 Divorced Completed 1955 Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working other than Elementary/Secondary (0-12) College (1-4 or 5+) disablea and Mental Hygiene. is marked other tha the disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fowlkes Hrizona Smith ichard 19a. Informant's Name/Relationship (Type, Print) - mother 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
6 Strebr Rd Edgemere, MD 21219 Health em 27 Arizona 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 8/28/12 Baltimore, 4 Donation 5 Other (Specify) Crematory Willow Spring Rd 21222 22. Name and Address of Facility . Signature of Funeral Service Licensee Jaramille 1SKWWW Bradley-Ashton Funeral Home 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart to ure. List only one cause on each line. Approximate Inte - Between - Ét ind Death Immediate Cause (Final Physician/ DIC disease or condition resulting in death) Medical EXMINER Due to (or as a consequence of): CERTIFICATION OF PROVED BY MEDICAL Examiner SEPHE SMOCK Sequentially list conditions, Examiner cause (Disease or injury Due to for as a sunscalar as of -tran LEFT PSOAS Absuss and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Completed by Physician/Medical Motor Vontele Collism in 2004 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter Id be detached for t in the past 12 months?

1 Yes 2 No Month Day 9 Unknown ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been sireal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: \_2 🗌 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After iniury Accident 5 Pending I DURUDUM 1 ☐ Yes 2 No Privar of car his pole Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined ROADWA UNKNOWI Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🛄 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 18 102740 8/26/2012 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 South Greene Street

22.

32. Registrar's Signature

Wan-Tsu Chana (Month, Day, Year)

SEP 0 4 2012

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ AMonth 5+ Cooper 100 3:149 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6670 Vincent Lane #202 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 215-86-1871 1 🛛 M 2 🗆 F 06/28/1962 Maryland Usual Residence of Decedent the Maryland td other then "neturel", or items 23e or 28e-f sho avant, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6670 Vincent Lane 21215 USA filed within 72 hours after deeth 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give altimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Specify Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade Self Employed College (1-4 or 5+) Home Improvement Be 17. Father's Name (First, Middle, Last) i. Pege 1 end 2 should be filed tment of Heelth and Mental H tent: If Itam 27 is markad ot jury or othar treumetic avar 18. Mother's Name (First, Middle, Maiden Surname) Leo J. Cooper Sr. Shirley Lee Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Hackett/Sister 2321 Mosher Street Baltimore MD.21216 20a. Method of Disposition 20b. Place of Disposition (Name of Depertment of H Importent: If Its eny Injury or of once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/04/12 Dundalk, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ NO-Stage Curpionyopall disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) ettending physician and for use es the burlel-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 9 | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cete has been sig ; pege 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Hospital or Attanding Physicien: The 24 hours after death. Funeral Director: After this certificete I ettely filled in by the funaral director, peg 1 Yes 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗍 No 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) m Si Windh D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5203 Ba Homore MD ZIKO 9 NSUMAPAKSEMD 283 S Smin /N 31. Date filed (Month, Day, Year) State SEP 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Elaine Harkavy Clarke 28<sup>ay</sup> 2012 7:01 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5802 Nicholson Lane #1004 Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Months Hours Min. (Month, Day, Year) Director 118-32-3480 1 ☐ M 2 🗓 🗓 F 70 Yrs. 4-17-1942 New York iral", or items 23a or 28a-f shov Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Rockville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 5802 Nicholson Lane #1004 20852 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Divorced Completed Specify. White Year or Dates item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Harkavy Esther Levy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Clarke - Husband 5802 Nicholson Lane, #1004, Rockville, MD, 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 9-5-2012 Falls Church, Virginia 21. Signature of Funeral Service Licensee Brad Smetzer 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 years Immediate Cause (Final Priysician Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Ulsease or injury after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Completed 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 2 🗌 No Yes 2X No 1 🗆 Yes b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ê Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 29a. Certifier (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year) 67258 8-31-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Dr. Nicholas

Flaine

Farrel, MD- 6420 Rockledge Dr., Bethesda, Maryland 20817

12-06601	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg	aible.		
David Lee Chevillar	State of Maryland / Department of Health and Mental Hygiene	1144.5	12	2794
1- For State Registrar	Certificate of Death Re	<b>∠</b> U i eg. No.	1	2134
Physician/ 1. Deceden	nt's Name (First, Middle,Last)	th	3. Ti	ime of Death

		1- For State Registrar	Certifica	ate of Death	R	2 U I	2 2134
Physici Medical Exam		David Lee	Chevil	lar	2. Date of Dea Month Septembe	th Dav Year	3. Time of Death 0617 hrs
*		4a. Facility Name (if not institution, give st Penninsula Regional Medical		4b. City, Town, or Location of Dea Salisbury	th	4c. County of Death Wicomico	
Funeral Director		5. Social Security Number 6. Sex 178-56-6751 1XM  Usual Residence of Decedent	2□F 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24H Months Days Hours Mi		th(MM/DD/YYYY) 9. Bird Foreig Cor	hplace (State or n untry)
vlaryland 28a-f show any d. at once.	tor	10a. State 10b. County Worces	ter Poc	omoke City			10d. Inside City Limits 1 Yes 2 No
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	al Director	33961 Man	Ket St. E.	xt. 21851		Og. Citizen of What Cour	
	by Funeral	3 Vildowed 4 Divorced in	Dates:	<ol> <li>Was Decedent of Hispanic Origin? (S         If Yes, specify Cuban, Mexican, Puert</li> <li>Yes 2 No specify:</li> </ol>	o Rican, etc.)	White, etc.	unite
215-0036 be filed within 72 hours afte nital Hygene. rked other than "natural", ent, the Medical Examiner	Completed	15. Decedent's Education (Specify only h Elementary/Secondary (0-12)	College (1-4 or 5+)	lecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use re Telemetry	Tech	16b. Kind of Business/li	ov't
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medics	To Be Co	17. Father's Name (First, Middle, Last) Roland Luciau  19a. Informant's Name/Relationship (Type,	Print) a VIIIar	18.Mother's Nam  Mailing Address (Street and Number or	Lyn De	haiden Surname)	Neave
- P # # #	_	13 1 11 -1	Mar (father)	Disposition (Name of cemetery,	ve Ho	2 NOVEY 1	A17351
Baltimore, permit. Pages 1 a Department of He Important: Wite		1 Burial 2 Cremation 3 F 4 Dongtion 5 Other Specify: 21. Signature of Funeral Service Licensee	Removal from State cremato	y or other place)  F. H. & Cirematory  22. Name and Address of Facility	9/4/12.	Hanover	-PA
		23a. Part I. Enter the disease, or complicat	I hulle	wetzelf.H. £ ( enter the mode of dying, such as cardiac	-rem.	Hayover	DA 17331
Physician /Medical Examiner		failure. List only one cause on each li Immediate Cause (Final disease a. Aor	tic Dissection  to (or as a consequence of):	once the mode of dying, sour as cardiac	or respiratory arre	st, snock, or near	Approximate Interval 8etween Onset and Death
7	7	Sequentially list conditions, b	to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or hijury that initiated c.	to (or as a consequence of):				
executed an and al - transit		events resulting in death) Last Due	to (or as a consequence or).				
	/Medical		MENDED				
± 50	Physician/N	22b \A/aa da da-da ta ta	Pregnant at time of death 5	Fetal death 3 Ectopic pregn. Other (Specify)	ancy	23d. Date of delivery Month Da	ay Year
ires that the signed by the detached	2	Part II. Other significant conditions con	tributing to death but not resulting	n the underlying cause given in Part I.		pacco use contribute to the	
ords, w require s been sig	leted		<del>-</del>		24a. Was al	n 24b. Were auto	ppsy findings available
tal Reco	Completed				perform 1 ✓ Yes 2	ned? death?	mpletion of cause of
Vital Rec ysician: The l his certificate l director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	al: 1 ✓ Inpatient 2 ER/Out	26.Place of Death (Check patient 3 DOA Other Nursin		tesidence 6 Other:	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should I.	<b>⊢</b> ∤	27. Manner of Death  1  Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	ne of Injury 28c. Injury at Work?		ow injury occurred	
Divisi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rura ate)	al Route Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medical Examiner: On t	o the best of my knowledge, death he basis of examination and/or inv manner stated.	occurred at the time, date and place, and estigation, in my opinion, death occurred a	due to the cause at the time, date a	(s) and manner as stated and place, and due to the	l. cause(s)
	Σ	29b. Signature and title of certifier	and	29c. License number O.C.M.E.		29d. Date signed (Mont. September 2, 201	
	-	30. Name and address of person who comp Pamela E. Southall, MD Ass	eted cause of death (Item 23a) sistant Medical Examiner	900 W. Baltimore Street, Balti	more, MD 21		
Sta Regist		31. Date filed (Morith, Day, Year)  SEP 0 4 2012	L. Hogistrar's Signature	all.			
DHMH 17 Rev 1/20		SEP W 4 CUIC	ORIG	SINAL	<del></del>		
OCMF 2006				•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANNE ADAMS COULBOURN August 31°, 2012° 6:50 .P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BLAKEHURST COMMUNITY HEALTHCARE Towson Baltimore County Social Security Number 1 Year If Under 24 Hrs. Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Director 212-30-9795 1 □ M 2 🗓 F 82 Nov 14, 1929 Maryland 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County 1 Tes 2X No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 1055 West Joppa Road, #225 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes If Yes, Give e filed within 72 hours after tal Hygiene. ed other than "natural", o 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname) Francis Blackford Adams Annie Shorter Young permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie V. Wethered (Daughter) 835 West 35th Street, Baltimore, Maryland 21211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other pla-Metro Crematory, Inc. Catonsville, Maryland 9/4/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie of Automotion MITCHELL WIFDEFFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) ance Month Medical Due to (or as a consequence of): <sup>1</sup>Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Dause (Disease or rijur) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Day Year To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 D No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier  $\Delta$ 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANUES

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST airua OX. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOSEPH MEDICAL TOWSON BALTIMOR 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 409-48-5 Hours Min. Director 1 - M 2 7 F 80 lennessee ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No DALTI MOR ELANI 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21053 9900 Middle death v 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No \$ 1 Never Married 2 Married hours after 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) filed within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ohn 0 ris tran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 922 altimore, lethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Monkton WO 16924 Fron Services-Montera or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. Immediate Cause (Final Onset and Death Physician/ HEAK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No ဥ 1 Npatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) onth, Day, Year) Registrar's Signature State SEP 0 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 28, SHIRLEY CANAPP 2012 1:50 P Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 213-32-6856 Director 1 🗆 M 2 🗓 F 76 Maryland Oct. 28, 1935 show 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Maryland Harford County Street 1 Yes 2 X No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3404 Grier Nursery Road 21154 United States ed other than "natural", or items event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 XNo Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Aberdeen Proving Grounds 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Shepherd Lucille Cullum permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Raymond Canapp (Husband) 3404 Grier Nursery Road, Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Aug. 30, 2012 | Forest Hill, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Fivens Funeral Chapel & Cremation Services — Bel Air
B Newport Drive, Forest Hill, Maryland 21050 ch 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 15disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Da 1 Yes 2 No 3 Probably 4 Unknown CAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PVD performed' Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 1 🗌 Yes 2 No ျု 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Watural 5 Pending work? 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD 31. Date filed (Monti

Registra DHMH 17 Rev 06-2011

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

032255

21014

BEL AIR, MD.

29d. Date signed (Month, Day, Year)

Augus - 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dav Annie Wong Chin 26 2012 10:10AM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Potomac Valley
Nursing and Wellness Center
Social Security Number | 6. Sex | 7. Age | Rockville f Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) 578-62-9688 Director 1 □ M 2 🛛 F 95 March 30, 1917 Usual Residence of Decedent California Pege 1 end 2 should be filed within 72 hours after death with the Maryland ment of Heelth end Mental Hygiene.
ent. If Item 27 is marked other then "naturel", or Items 23e or 28e-f show ury or other treumetic event, the Medical Evan in a must be notified at you other treumetic event, the Medical Evan in a must be notified. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10900 Barn Wood Lane 20854 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Year or Dates Asian 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lim See Frank Wong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10900 Barn Wood Ln., Potomac, Maryland 20854 Carol Lefkowitz / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of George crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1
Depertment of 8
Importent: If its
eny injury or of 1 X Burial 2 Cremation 3 Removal from State September 1, 2012 Washington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland <sup>22.</sup>Name and Address of Facility Robert A Rockville, Inc. 300 Wes Rockville, Maryland 208 21. Signature of Fune A Se Alexa Licens Pumphrey Funeral Home/ Montgomery Avenue 0-2805 M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 days Immediate Cauce (Pinal Pnysician, a Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dementia years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the deeth certificate be executed ettending physicien end I for use es the burlei-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death ed by the e detached 1 <u>0</u> signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 N After this certificate 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 🔀 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 \(\infty\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \(\sum \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 \(\sum \) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

<u>Anurita Mendhiratta</u>

31. Date filed (Month, Day, Year)

D38262

9043 Shady Grove Court, Gaithersburg, Maryland 20877

August 27,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug 283 2012 6:50P Henry Lamotte Dodrer Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospice Dove House Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Hours Days Min 215-36-7959 Director 02/5/1922 90 Usual Residence of Decedent 27 is marked other then "natural", or items 23a or 28e-f shov traumatic event, It. Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll Westminster 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21157 2036 Nicodemus Road 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 1 and 2 should be filed within 72 if Health and Mental Hyglene, item 27 is marked other then ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dairy Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ethel Stella Ranoull Herbert Dodrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1434 E. Deep Run Rd., Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) Dixie Tasto-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Depertment of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1/12 Finksburg Evergreen Mem 21. ignature of E ral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation 254 E. Main St., Westminster, MD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physicien: The law requires that the deeth certificate be executed use as the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ģ in the past 12 months? Month 5 Other (specify) Day Vear Pregnant at time of death 2 | No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 After this certificate 1 Yes 2 - No funeral director, 25. Was case referred to medical | e 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) INPATIENT 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No e Hospital or Attendin 124 hours after death. e Funeral Director: Aft the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse, Pracitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 only on 29b. Signatur nd title of certifier License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary M. Dannenfelser August 29, 2012 4:20 р м Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 246-36-9657 Hours Director 1 🗆 M 2 🔀 F North Carolina 87 November 3,1924 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10b. Count with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits M. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1617 Delvale Ave. 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give 1 Never Married 2 Married Black, White, etc. þ 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other that any injury or other traumatic event, the 1 once. Nurse Medical 12 years years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James A. Murray Martha Strickland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Dannenfelser Daughter 1617 Delvale Ave. Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 6, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Cross Cemetery Middlesex, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 2012 of Funeral Septice Lidenstee 21. Signata 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. M01176 7110 Sollers Point Road, Dundalk, Md. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause oppeach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) \*Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 🔲 Ectopic pregnancy 1 Yes 2 Pregnant at time of death 5 Other (specify) Month a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes ☐ Yes 24 hours after death.

Funeral Director: After this certifice letely filled in by the funeral director, i Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Sp 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely fil 29a. Certifier (Check only one 29b. Signature a ompleted cause of death (Item 23a) (Type State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:00 A M Physician/ Diorio 28 Joseph August Anthony Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Co. Glen Burnie Glen Burnie Health & Rehab. Center If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year) 120-24-0901 1 X M 2 □ F Director 80 New York 06/26/1932 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. Count with the Maryland must be notified at Director 1 Yes X No Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Funeral 23a United States 21061 7502 Jacqwill Road 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1953 - If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner Black White etc 1 X Never Married 2 Married ō by White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Accounting the Accountant 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Filomonia Arcomone Thomas Diorio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 21061 Glen Burnie, MD 7502 Jacqwill Road Mrs. Cheryl E. Small Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burlal 2 Cremation 3 Removal from State ō Glen Haven Mem Park 09/04/2012 Glen Burnie, MD 4 Donation 5 X Other (Specify) Entombmen injury 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral S any Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events set this initiated events.) Examine physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 2 NO 1 Yes ည 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death work? 5 Pending Natural Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide ☐ Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital Certificate: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of ce of death (Item 23a) (Type, Print) who completed cause 30. Name and address of person State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20:46 Vincent August 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 215-40-5467 (Month, Day, Year, Director Maryland December 28a-f show 10c. City, Town or Location Director 10d. Inside City Limits Items 23a or 28a-f slaer must be notified Baltimore 1 X Yes 2 No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1215 Argyle Ave. 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
1f Yes, Give "natural", or item ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 11th Grade Disability 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental F tem 27 is marked o Vincent J. Day Sr. Alice R. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 Argyle Ave., Baltimore, MD 21217 Angela Day(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Date or - 10 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Crownsville Cem. Department of Important: If any injury or 09/07/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup>Josephdren of Fabrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Lung Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Peripheral Vascular 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? certificate has performe 2 No 25. Was case referred to medical Be examiner? 26. Place of Death (Check only one) To the Hospna.
within 24 hours after death.
To the Funeral Director. After this cer
completely filled in by the funeral director. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier, 1285900803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene St. Baltimore, MD 22 Adnan 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

SEP 0 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #26 Per PHY G931 9/04/2012 JH State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Emil Daub 7:04Medical 8/22 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3104 Wheaton Way, Apt. H Ellicott City Howard 5. Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours Min. 84 Director 147-22-5357 5/8/1928 Germany Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits NJ 1 X Yes 2 No Bergen Lyndhurst 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 621 Fourth Street 07071 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 1 X Yes 2 □ No If Yes, Give 1950-1952 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Divorced other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Tool & Die Maker Jewelery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emil Daub Linda Wilerat Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary Lou Daub, Spouse 621 Fourth Street, Lyndhurst, NJ 07071 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) East Ridgelawn 08/25/2012 Clifton, New Jersey . Signature of Fureful Service Harman Harman Funeral Service, PA 22. Name and Address of Facility 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year ☐ Pregnant ☐ Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 1 Yes 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Daughter's Other: 1 🗌 Yes 2 No မ 5 Residence 6 Kether (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Home 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 XNatural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: ⊥ Accider □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F only one 29b. Signature and title of g 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 Columbia MD 8104 filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7.8perFH.G931.9/6/2012 WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2:45 A M August 26, 2012 Josephine Α. Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooklyn Park Hammonds Lane Center Anne Arundel Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) 1922 Country) 1923 Maryland **Funeral** Days Hours Months 1 □ M 2 🗓 F 89 Director Oct. 6: 214-26-3221 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be multipled at 1 XYes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 1535 Marshall Street 21230 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: ò Specify. 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) jes 1 and 2 should be filed within 7 tof Health and Mental Hygiene. If item 27 is marked other than "n v other traumatic event, In a Med Elementary/Secondary (0-12) College (1-4or 5+) Schrieder Brothers N/A 6 Meat Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Luckhardt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Davis (Son) 406 Holy Cross Road Brooklyn Park, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Pk. 08/29/2012 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
130 East Fort Avenue Baltimore, Maryland 21230 21. Signature of Funeral Service Licensee MOO-732 23a. Peri 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical CARDIO-VASCULAR DISFASE Due to (or as a consequence of): TERIO-SCLEROTIC **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine P.O. Box 68760, attending physician and for use as the burial-trar Due to (or as a consequence of) the death certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 30. Name and a tires of person who complete that se of death (tem 23a) Type, Frint // ( -// 31. Date filed (Month, Day, Year) SEP 0 4 2012 132. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Elgert August Jane 1:20 AM 28,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Dulaney Valley Assisted Living Baltimore Cockeysville Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 217-20-9012 Director 1 M 2 X F 87 Yrs Maryland Oct. 9, 1924 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State must be notified at 10c. City, Town or Location Director MD Baltimore Parkville 1 Yes XX No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 2104 East Joppa Road 21234 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. white Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Me C & P Telephone Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Elmer Elgert Marquerite Himler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Elgert-brother 2104 East Joppa Road-Parkville, maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Parkville, Maryland Aug. 31, 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel and 8800 Harford Road-Parkvi 21. Signature of Funeral Service Licenses l Cremation Services lle.Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ ZHEIMER EMEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequeritally flet equilitions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mo Month Day Pregnant at time of death the Unknown g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has by page 2 s autops 2 1 No this certificate 1 Yes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence To the Hospital or Attentums ...,
within 24 hours after death.
To the Funeral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) JUGUST 30, 2012 ale MV who completed cause of death (Item 23a) (Type, Print) NGACE, MD Home PASSICIANS PC BIZPHEN D

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:22 A 2012 Lucy Elizabeth Foster August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1600 Hollingsworth Road Harford Joppa Social Security Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1928 1 □ M 2 🂢 F Months Days Hours Min. July 16, Virginia 223-40-2303 84 Director Usual Residence of Decedent show 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Harford Joppa 1 ☐ Yes 2 X No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21085 1600 Hollingsworth Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Director of Family Services State of Connecticut Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic even permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked on any injury or other traumatic eve Amanda Virginia Butler Wade H. Foster, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 Kirkham Street San Francisco, CA Margaret M. Edwards - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Foster Family Cemetery 9/1/2012 Warrenton, VA 4 Donation 5 Other (Specify) Signature of Juneral Service Licen ዝድማሪያቸር ልናቸውቸህ neral Service 5517 Vine st., Alexandria, VA 22310 Menn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final zheime <sup>o</sup>nysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 送 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatule of person who completed cause of death (Item 23a) (Type, Print)
OLVIN, MD. Johns Hopkins Bayview, Baltimore, Maryland 30. Name and addres COLVIN MD.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Throughout Name (Print Notice Later)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Print December 2 (1987)  Revis Lee  Revis Lee  Print December 2 (1987)  Revis Lee  R	evin Lee Franci		S 1- For State	state of Maryla		artment o		and	Menta	al Hy	giene		20	)   2	2 2	2795
Security   Let   France   Security   Let   Let   Let   Security   Let	Physicia			dle,Last)		rimodio o	Dodan			2	2. Date of D		0.		3. Time o	f Death
As Secul Newson Control Name    Tripo Baltimore   Secul Name   Secul N		-			2							Day 27, 20	Year		0831	hrs
Second Security Number   15 Second Security Number   15	*						4b. City, To	wn, or L	ocation of					Death		
216-25-9209   TX			11760 Baltimore Ave	nue			Beltsvil	le					Prince G	eorge'	S	
State   Stat			5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)					8. Date of	Birth(M	M/DD/YYYY)	9. Birth	place (St	ate or
10.0 Sizes   10.0 Country   10.0 Sizes   10.0 Country   10.0 Sizes   10.0 Country   10.0 Sizes   10.0 Country   10.0 Sizes   10.0 Siz	Director		216-25-9209	1 XM 2 F		36 Yrs	Months	Days	Hours	Min.	May 2	9,	1976	Cou	ntry Was	h. DC
MD Prince George's Lanham  100 Speal and Number  100 Speal and Num		Ì	Usual Residence of Decedent													
To Show and Number   To Show	v any		10a. State 10b. County	/	10c. City,	, Town or Locat	ion									,
98 OF STATE OF THE PROPERTY OF	and show	ь	MD Princ	ce George's	Lan	ham									1 1 Ye	s 2 No
Nower Harman Salada   Nower Harman Salada	Maryl 28a-1	ect	10e. Street and Number	-			10f. Zip C	ode				10g. C	itizen of Wha	at Count	гу?	
Nower Harman Salada   Nower Harman Salada	an the 3 or		9302 Rolling V	View Drive			2070	06				USA	A			
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	h with	era	11. Marital Status	12. Was Dece								No-			an Indian,	, Black,
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	or ite	딆		1 Yes			_	-			, ,				-k	
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	s after			or Dates:		I 1		Λ.		nd of wo	rle dono	lach				
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	hour natu	ted										TOD				
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	36 nin 72 than	e e				В	usine	ssma	ın				Pri	vate	5	
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	d with	ĕ	1 Z L II 17. Father's Name (First, Middle	e, Last)		<u>.                                    </u>		18	3.Mother's	Name (I	First, Middl	e, Maide	n Surname)			
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	215 e file tal Hi ked o								Patr	icia	J. N	[ann	ing			
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	21.	2				19b. Mailin	g Address							, State,	Zip Code	)
1   Surini 1   2     Cremation 3   Removal from State   1     Removal from State   1	MD 12 sh th and 27 is		Denise Francis	s/Wife												
Physician   Medical Examiner   1/2/14	Te, land Heal		· · · · · · · · · · · · · · · · · · ·	Domaval fra				of ceme	etery,		Date	200	c. Location -	City or T	own, Stat	e
Physician   Medical Examiner   1/2/14	MO Pages ent of int: 1	-			III State			nete	rv l	09-0	8-201	2 B <sub>1</sub>	rentwo	od.	Mary	land
Physician   Medical Examiner   1/2/14	partin mit.					22.1	lame and A	ddress c	of Facility	J.B.	Jenk	ins	Funer	al I	Home,	Inc.
Revision of Europe Consect and Death   Death	<b>2</b> 2 2 <b>2</b> 3	_	>> < C	Ka		-	7474	Lan	dove	r Rd	. Нуғ	tts	ville,	MD		
Part II Other significant conditions of any leading to immediate Gause (Final disease or condition resulting in death). Last Due to (or as a consequence of):    Due to (or as a consequence of):			23a. Part I. Enter the disease, of failure. List only one caus	or complications that can be on each line.	used the death	. Do not enter t	he mode of	dying, sı	uch as car	diac or r	respiratory	arrest, s	hock, or hea	t	Between	n Onset and
Due to (or as a consequence of):    Control   Security				e a. Phen	cyclidi	ne (PCF	) Int	oxid	atio	n					· [	Death
Target   T			or condition resulting in death)	Due to (or as a	consequence o	of):										
Very State of Death (Check only one)  23d. Date of delivery  Month Day Year  Work of Specify)  1   Yes 2   No 3   Probably 4   Unknown  Part II. Other significant conditions   2   Exposure of pregnancy   1   Yes 2   No 3   Probably 4   Unknown  Part III. Other significant conditions   2   Exposure of Death (Check only one)		-a		Due to (or as a	consequence o	of):								-		
Very State of Death (Check only one)  23d. Date of delivery  Month Day Year  Work of Specify)  1   Yes 2   No 3   Probably 4   Unknown  Part II. Other significant conditions   2   Exposure of pregnancy   1   Yes 2   No 3   Probably 4   Unknown  Part III. Other significant conditions   2   Exposure of Death (Check only one)		틭	cause Enter Underlying Cause	C										_		
AMENDED 23a,27,28a-f per me g931 9-28-12 vt    FEMALE:	-	Exa	events resulting in death) Last		consequence o	of):										
FEMALE:   FEMALE:   23d. Date of delivery   Month   Day   Year	execut m and I - tra	g	₩ LINPENDED		232 27	7 20a_f	nor r		031 0	1_20	_12 77	+		$\neg$		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   yes 2   No 3   Probably 4   Vulnknown   24a. Was an autopsy performed?   1   yes 2   No 3   Probably 4   Vulnknown   24a. Was an autopsy performed?   1   yes 2   No   1   yes 2   No   1   yes 2   No   No   1   yes 2   No   No   No   No   No   No   No		ğ					per n	e g	731 3	-20	-12 V		3d Date of c	delivery		
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   yes 2   No 3   Probably 4   Vulnknown   24a Was an autopsy performed?   1   yes 2   No 3   Probably 4   Vulnknown   24a Was an autopsy performed?   1   yes 2   No   1   yes 2   No   1   yes 2   No   No   No   No   No   No   No	ox 6	Sici		mlum avvim   '		eath 5 O	her (Specif)	()				- 1				
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	he des	ڇَ		9 01187101		osulting in the	ınderlying e	ause div	en in Part	1	23e Di	d tobacc	o use contrib	ute to t	ne cause	of death?
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	P.O.	含	. <u> </u>	The solution of the	00011120111011			9/1			1	Yes 2	No 3	Proba	ably 4	Unknown
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	ds,	ted									24a. W	as an	24b. W	ere aut	opsy findir	ngs available
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	law re	톍	-							_					mpletion	of cause of
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Reficate	ઢા										s 2	No 1	Yes	2	No
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	cian:	Be	examiner?	I Hospital:		FD/O destion		10				7 Basis	donos 6	Othor	Caopo	-
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Phys Phys er this	리		- ' "		· ·									Scene	
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	oding nding th. : Aft	<u> </u>	1 Netural	(Month,	Day,Year)				_							
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29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Div	삙	det	uld not be					•					Ba	ltimo	ore Ave
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Hospi 14 hou Puner ely fil		29a. Certifier	Physician: To the best				me, date	e and plac					as state	d.	
29b. Signature and title of certifier  29c. License number O.C.M.E.  August 28, 2012  30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	o the orthon thin 2 or the orthon	diç				and/or investiga	tion, in my o	pinion, d	death occu	urred at f	the time, da	ate and p	olace, and du	e to the	cause(s)	
30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year)  S2. Registrar's Signature	F 3 F 3	Me	29b. Signature and title of certif		01		29c. l	icense	number			290	l. Date signe	d (Mont	h, Day, Ye	ear)
Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	U.A.		10/11	111	It			D.C.M	I.E.			Αι	igust 28,	2012		
Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	okpen.		30. Name and address of perso	on who completed cause	e of death (Item							-				
State 31. Date filed (Month, Day, Year)  S2. Registrar's Signature								Stree	t, Baltim	nore, N	MD 2122	3				
		200		) 32. Reg	gistrar's Signatu	barker	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 Te 2012 :0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 109 Ceure NIC THOTEL 1ed nne ashington 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min. Hours **Director** 215-50-6818 1 □ M 2 🕱 F 89 Usual Residence of Deceden 03/19/1923 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Ferndale Anne Arundel 9 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? 21061 7187 Baltimore Annapolis Boulevard U.S.A. ral", or items? death Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 □ Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. alth and Mental Hygiene.

27 is marked other than raumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MaryLou Zettie Hubbard Dana H. Mise 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Ferndale, MD 21061 Ms. Pamela G. Foster / 7187 Baltimore Annapolis Blvd, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park: 8/31/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD <del>M01</del>357 Singleton Funeral & Cremation Services, P.A. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate nterval Between Immediate Cause (Final disease or condition Onset and Death Physician/ CMd wascula defea resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury as the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 2 No Month Dav Pregnant at time of death Yes 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed: certificate Yes 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death Time of Certificate: 28b. 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury filled in by the Accident Investigation Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the within To the 29b. Signature and title 29d. Date signed (Month, Day, Year) 28 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

0 4 2012

Balto, mo alaau

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 27958 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201<sup>Yea</sup> 23, Beverly Ann Fant August 10:20 AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital N/A Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 214-40-1249 Director 1 □ M 2 X F Dec. 29, 1941 Maryland 70 Usual Residence of Deced 28a-f show death with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ler must be notified 1 ☐ Yes 2 🛣 No Marvland Brooklyn Park Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Funeral 5706 Johnson Street U.S.A. 21225 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, marked other than "natural", or iter matic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 [**X** No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Tes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Homemaker Own Home 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 is marked o မ Raymond Glass Lillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence D. Fant, Jr (Husband) 5706 Johnson Street Brooklyn Park, Maryland 21225 item 2 20a. Method of Disposition
1 □ Burial 2 ÎX cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ± 5 cemetery, crematory or other place permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Bayview Crematory 08/28/2012 Baltimore, Maryland 21. Signature of Funeral Service Licenses M00 - 732Funeral Avenue Home, P.A. Baltimore, Maryland 212**2**5 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Jeth Jeth Jeth Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner auunitially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mor Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No Director: After this certificate 25. Was case referred to ... dical Certificate: To Be 26. Place of Death (Check only one) examiner? Inpatient 2 [ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accider
Suicide Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 29b. Signature itle of certifier (Man P3a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year

SEP 0 4 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				eartment of Health and M	ental Hygie	ene	07050
	_		Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg 2. Date of Death	. No. /	2/939
	Physicia		EDITH FRANK			Day 2012	3. Time of Death 4:35 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Medebi	4c. County of Death	
	1		NORTH OAKS	BALTIMORE		BALTI	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birtl	nplace (State or Foreign
	Director		Usual Residence of Decedent		(Month, Day, Ye 05/24/1	921	MA
	and show i at	'n		ocation	·		10d. Inside City Limits
	Maryl 28a-f otified	rect	MD BALTIMORE BALTI	MORE			1 🗆 Yes 2 🔀 No
	h the	<u>a</u>	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	untry?
	th wit	<b>Funeral Director</b>	725 MT. WILSON LANE	21208		USA	
^	or dea	by Fu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
2	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	q pe	3 Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2 💢 No Specify:		Specify:	HITE
21215-0036	2 hour "natu dical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16	b. Kind of Business I	
121	than 7:	,om	Elementary/Seconday (0-12) College (1-4 or 5+) life. I	OO NOT use retired)		T DOLLT	DD T 45
N	e filed wit tal Hygie ed other event, th	Be	12 AD	MINISTRATIVE ASSIS' 18. Mother's Name		T. ROWE	PRICE
an	ild be fill Mental narked o	မ	MANUEL FRANK	TILLIE	(i iist, iviidale, iviaic	•	SHORE
Maryland	1 and 2 should by f Health and Mer item 27 is marke other traumatic			ing Address (Street and Number or Rural	Route Number, Cit		
	and 2 s Health sem 27 ther tra			34 ASHLEY WAY, OWI	NGS MILLS	s, MD 211	17
ore		ı	20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  20b. Place of Disposerery, cree	osition (Name of D matory or other place)	ate 200	c. Location - City or 1	Town, State
baltimore,	t. Page ntment o rtant: If njury or		4 Donation 5 Other (Specify)  BETH EL		0/2012	RANDALLS	TOWN, MD
n n	permit. Page Department ( Important: If any injury or once,					ON & BROS.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	8900 REISTERSTOWN : ter the mode of dying, such as cardiac or		ESVILLE,	MD 21208 Approximate
e~.	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition  ALZHEIMELS	Sugaria			Interval Between Onset and Death
	Medical	ì	disease or condition resulting in death)  a. Due to (or as a consequence of):	JMINIT		-	
	Examiner	_	Sequentially list conditions, b.				
-	d sit	nine	if any, leading to immediate Due to (or as a consequence of):				
	and I-trans	Exar	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):				
_	e death certificate be executed the attending physician and hed for use as the burial-transit	dical Examiner					
2/00	ficate g phy as the	Medi	Lesenne Les				
200	r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Sctopic pregnancy		23d. Date of deli-	/ery
POX	death he att	Physician/Me		Other (specify)		Month	Day Year
j.	at the d by t detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tohacı	co use contribute to	he cause of death?
ν, L	ires th signe d be o	d by					bbably 4 Unknown
ecords,	/ requ	lete			24a. Was an	24b. Were auto	ppsy findings available
ec C	he lav te has age 2	Completed			autopsy performed 1 Yes 2	prior to condeath?	ompletion of cause of
2	ian: T	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		NO I Tes	Z 🗆 NO
VICA	hysic his ce	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ne 5 🗆 Residence	e 6 Other (Specif	y)
5	ling P	ate:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	work?	8d. Describe how in	njury occurred	
VISION	death death ctor: / y the f	Certificate	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Of Lagation (Street	t and Number or Rura	A Doute Alumbay
Ë	al or A safter I Direct		4 Li Homicide determined building, etc. (Specify)	cot, factory, office	City or Town, St		i noute Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	due to the cause(s	and manner as stat	ed.
	the Hi nin 24 the Fu	Mec	(Check 2 Medical Examiner: On the basis of examination and/or investigation of the basis of examination and/or investigation of the basis of my knowledge.	death pecumid at the time, date and place	and due to the cos	iso(a) and marrier as a	tation .
	5 N W W		29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			20 Name and address of page with a small dark of the state of the stat	NOR BOS Z	140	14UST 29	12011
2			30. Name and address of person who completed cause of death (Item 23a) (Type, KNTHUSSNC. SiAUMA P.o. But 24/3	Solishung MAN	unus 2	21802	
	Stat		31. Date filed (Month, Day, Year) 32. Registrary Signature SEP 0 4 2012	,			
	Registra	r	DEF U & ZUIZ CENTURY 10. 1900				

12-06558

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ludith Ann Garland	Sta 1- For State Registrar	ate of Maryland		artment o rtificate o		l Mental		Reg. No. 2 (	112 2796
Physician/ Medical Examine	Decedent's Name (First, Middl						2. Date of De Month	ath Dav Year	3. Time of Death 0330 hrs
FEW CAI EXAMINE	4a. Facility Name (if not institution University Hospital		r)		4b. City, Town, or t	ocation of De	August 3	4c. County of	
Funeral Director	5. Social Security Number 218-02-2600	6. Sex 7. A	ge (In yrs. Ia	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24 Hours	Min		9. Birthplace (State or Foreign Country) MD
w any	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat					10d. Inside City Limits 1 Yes 2 No
the Maryland t or 28a-f show tified at once.  Director	MD Carre		<u> </u>	aneyto	0Wn 10f. Zip Code 2178	7		10g. Citizen of Wha	at Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	146 Carnival  11. Marital Status 1 Never Married 2 Marital	12. Was Deceder Armed Forces 1 Yes			as Decedent of Hisp es, specify Cuban,	panic Origin? Mexican, Pue	( Specify Yes or N	o- 14. Race - White,	American Indian, Black, etc.
2 hours after "natural", "I Examiner I	3 Widowed 4 Div.  15. Decedent's Education (Specific Elementary/Secondary (0-12)	orced If Yes, Give Year or Dates: cify only highest grade co			Yes 2 No nt's Usual Occupation ost of working life.	on (Give kind		Specify: V	White iness/Industry
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exan Completed	9 17. Father's Name (First, Middle,	1.20		Assis	tant Mai		ama (Eirat Middle	Food Se	ervice
215-1 be filed ntal Hyg rked off ent, the	Richard Ear	l Garland	Sr.			Mary	Ann Al	len	
ID 21 2 should and Me 27 is man matic ev	19a. Informant's Name/Relations Mary Ann Ree							mber, City or Town,	
re, N s 1 and 2 of Health If item 3	20a. Method of Disposition  1 Burial 2 Cremation		state	Place of Dispos crematory or ot	sition (Name of cem her place)	etery,	Date		City or Town, State
Itimo it. Page rument o ortant: y or oth	4 Donation 5 Other Sp 21. Si nal confirmati Service	pecify:	Sou		rroll C			Winfie	eld l & Crematio
Ba Perm Depa Impe				25	4 E. Ma.	in St	. Westm	inster,	MD 21157
Physician /Medical	23a. Part I Enter the disease, or failure. List only one cause Immediate Cause (Final disease	complications that cause on each line. a. Chest and Abd			he mode of dying, s	such as cardia	ac or respiratory a	rest, shock, or hear	t Approximate Interval Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a con							
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence o	f):					
nted d ansit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cond	sequence o	f);					
0, be executed sician and burial - transit	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Univ	4 Pregnant a	ome of preg	2 Fe	etal death 3 her (Specify)	Ectopic pre	gnancy	23d. Date of d Month	elivery Day Year
P.O. B that the day the detached is detached by Phy	Part II. Other significant condit		ath but not re	esulting in the	underlying cause gi	ven in Part I.			ute to the cause of death?
ords, P w requires the very significant of the very should be defered by		<u></u>					24a. Was	s an 24b. W	Probably 4 Unknown ere autopsy findings available
tal Records, cian: The law required certificate has been signetor, page 2 should be Be Completed					26 Diago	of Dooth (Cho	1 ✓ Yes	ormed? de	ior to completion of cause of eath?  Yes 2 No
Vital hysicians this certi I director	25. Was case referred to medica examiner?  1 Very 2 No	Tree 10 1	ient 2 🗹	ER/Outpatient		of Death (Che Other 4 Nu	rsing Home 5	Residence 6	Other:
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th oous after death.  Peral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach Certification: To Be Completed by P	27. Manner of Death  1 Natural 5 Penc 2 Accident Inves	stigation	Year) 2	28b. Time of 1 0007 hrs	f Injury 28c. Injury at Work?  1 Yes 2 No 28d. Describe how injury occurred Pedestrian struck by vehicle				cle
Divis pital or A ours after icral Directified in b		d not be 28e. Place of (Specify) Lo			et, factory, office bu	uilding, etc.	or Town.		or Rural Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	(Chican only	nysician: To the best of a miner:On the basis of ex and manner stated	amination a						
# \$ H 5   \$	1	eur			29c. License O.C.N			29d. Date signed August 31, 2	d (Month, Day, Year) 2012
Le	30. Name and address of person Laron Locke MD. A	who completed cause of ssistant Medical Ex			altimore Street	, Baltimore	e, MD 21223		
State	31 Date filed (Month Pay Year)	32. Registr	ar's Signatu	ure	<del></del>				···

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

1- For State Certificate of Death	
Registrar	Reg. No. 2012 2796
	Day Year 1414 hrs
4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Brighton Dam Road  Brookeville	4c. County of Death  Montgomery
	Birth(MM/DD/YYYY) 9. Birthplace (State or
Months Dave House Min	Foreign Country) S.C
Usual Residence of Decedent	
M	10d. Inside City Limits  1 Yes 2 No
Md. Howard Columbia  10e. Street and Number 10708 Bridlerein Terrace 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	10g. Citizen of What Country?
10708 Bridlerein Terrace 21044	USA
11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
1 Yes 2 No  No specify:	Specify: Black
15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Give kind of work done during most of working life. Do NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle)	Constantion
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	Construction  e, Maiden Surname)
950 1 2 yrs.  1 2 yrs.  1 2 yrs.  1 2 yrs.  1 2 yrs.  1 2 yrs.  1 3 Mother's Name (First, Middle, Last)  Larry Greene  1 3 Mother's Name (First, Middle, Last)  Larry Greene  1 3 Mother's Name (First, Middle, Last)  Larry Greene  1 1 2 yrs.  1 2 yrs.  1 3 Mother's Name (First, Middle, Last)  Larry Greene  1 3 Mother's Name (First, Middle, Last)  1 3 Mother's Name (First, Middle, Last)  1 4 Mother's Name (First, Middle, Last)  1 5 Mother's Name (First, Middle, Last)  1 6 Mother's Name (First, Middle, Last)  1 7 Mother's Name (First, Middle, Last)  1 8 Mother's Name (First, Middle, Last)  1 9 Mother's Name (First, Middle, Last)  1 9 Mother's Name (First, Middle, Last)  1 9 Mother's Name (First, Middle, Last)	
Larry Greene (Father)  133 Tarpon Ct. Elloree ,S.C.  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date	20c. Location - City or Town, State
20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Euneral Service Licensee  22. Name and Address of Facility Haight Fu	2 Sykesville Md.
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Fu	neral Home & Chapel
P.O. Box 195 Sykesville,  Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as	Md. 21784.
/Medical failure. List only one cause on each line.	Between Onset and Death
examiner or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence of):	
Description of the past 12 months?  Office of the past 12 months?	
Of participation of pregnancy  1	23d. Date of delivery  Month Day Year
past 12 months?  past 12 months?  past 12 months?  The blad death of death	
The second secon	tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	es 2 No 3 Probably 4 Unknown
24a. Wa autter the special per special pe	s an 24b. Were autopsy findings available prior to completion of cause of
Ne composition of the compositi	formed? death? 2 No 1 ✔ Yes 2 No
1 ✓ Yes  25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5	Residence 6 🗸 Other: Scene
1 Ves 2 No rospital 1 Inpatient 2 ER/Outpatient 3 DOA Outer4 Nursing Home 5 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Described Day, Year Subject dr	e how injury occurred
To the stand of th	owned self
O se to the part of the part o	(Street and Number or Rural Route Number, City State)
A   Homicide   Specify   dam   Brighton Da   Brighton Da   Specify   dam   Brighton Da   Specify   dam   Brighton Da   Specify   dam   data   da	m Road, Brookeville, MD
# 1 4 4 5 6 6 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	
29c. License number	29d. Date signed (Month, Day, Year)
30, Name and address of person who completed cause of death (Item 23a)	August 25, 2012
Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, N	MD 21223
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar SEP 0 4 2012	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THOMAS AUGUST GREEN 28, 2012 11:30P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Mir 213-42-3020 Director 1 **X** M 2 □ F 69 10-28-1942 MARYLAND Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location Director notified 28a-f MD BALTIMORE 1 Yes 2 XNo MIDDLE RIVER 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 113 TRAILWAY ROAD 21220 U.S.A ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 11:30 р.ш. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE Specify: "natural", 3X Widowed 4 □ Divorced Year or Dates. 1960 and 2 should be filed within 72 hours Fleath and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) EQUIPEMENT REPAIRS CLOVERLAND DAIRY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2012 ည GREEN CHARLES R. KATHLEEN TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4104 LOCH CARROW ROAD DOLORES GREEN/SISTER BALTIMORE, MD 21236 28, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State August 4 Donation 5 Other (Specify) METRO CREMATORY 8-31-2012 CATONSVILLE, 21. Signatur of Funeral serve Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ LEUKEMIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ding 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Pregnant at time of death 5 Other (specify) signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Thomas should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 5 Pending 1 X Natural after death. Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 06-2011

State

Registrar

only one 29b. Signature and

TRACIE L.

Date filed (Month, Day,

SEP 0 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORGAN,

**CRNP** 

2300 DULANEY VALLEY RD.

29c. License number

29d. Date signed (Month Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 2012 Meredith Ann Glickman A M 4:30 Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 137 Lazy Hollow Drive Gaithersburg Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days Hours Min 8-28-1983 Country) Pennsylvania Yrs Director 28 INKNOWN Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MDMontgomery Gaithersburg 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 137 Lazy Hollow Drive 20878 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... Armed Forces? <sup>4</sup> ☐ Yes 2**Å** No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) None None Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold Glickman Sherill Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Glickman - Father 11321 Berger Terrace, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8-27-2012 4 Donation 5 Other (Specify) Judean Memorial Grdns Olney, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction are of Funeral Service ic nsee Brian Deibler 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Tachycardia Medical resulting in death) Due to (or as a consequence of): Examiner Morbid Obesity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affected.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlansit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlyin<mark>g</mark> cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Chronic Shortness of Breath 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 21 No 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury work? 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certific Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only 29b. Signatu and title of certifier 29d, Date signed (Month, Dav. Year) D0065182 8-27-2012

State Registrar

DHMH 17 Rev 7/2009

e int)

MD - 5215 Loughboro Road, NW, #300, Washington, DC 20016

30. Name and address of person who completed cause of death (Item 23a) (Type,

32. Regis dar's Sign

Sima Nourani-Zenuz,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Time of Death 3:30P M Physician/ August 29, 2012 SHIRLEY ELIZABETH GANTZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City UNION MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral**  $\underset{\mathsf{Sept}}{\overset{(Month,\ Day)}{19}} 1920$ Hours Colorado 522-26-6350 **Director** 1 🗆 M 2 💢 F 91 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director ms 23a or 28a-f s must be notified N/A Maryland Baltimore 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21211 USA 700 West 40th Street or items . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 143-145 Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give 2 should be filed within 72 nours .... th and Mental Hygiene. 27 is marked other than "natural", or 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US State Department Elementary/Secondary (0-12) College (1-4 or 5+) Secretary traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Elizabeth Miller Marvin E. Gantz, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1400 Front Avenue, Suite 202, Lutherville, MD 21093 Victoria L. Grace\_ (Pers. Rep. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 8/31/2012 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune of Section 1991 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TulmonAry d ISEASE Physician/ UBSTYLLCTIVE CHYUNIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEVTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 To the Hospital o Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s af er death. 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a
To the Funeral C
completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

-10x /k

State Registrar On mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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5901 north CHANCA Street Baltimore MAT

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2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LENORA Physician/ R. GANT 2234 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL COUNTY CARROLL HOSPITAL CENTER WESTMINSTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 476-17-0066 12/28/1935 LIBERIA Director 1 □ M 2 🔯 F 76 Yrs. Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 No Yes 2 □ No MD CARROLL WESTMINSTER 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 21157 USA 445 BARONETS CT Page 1 end 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 N Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) REGISTER NURSE PRIVATE 2Yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES REEVES GRETA ROBERTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHASHI CT. JASSA GANT MAJOR/DAUGHTER SMYRNA, DE. 19977 20a. Method of Disposition 20c. Location - City or Town, State LIBERIA Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 of Pepartment of Pepartment of Pepartment: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Louisiana Cem. 9/22/12 MONTSERRADO COUNTY CAPITOL MORTUARY Signal in of Funeral Service 22. Name and Address of Facility 1425 MARYLAND AVE NE WASH., DC 20002 complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the dise Approximate Interval Between Onset and Death shock, or heart failure. Lis Immediate Cause (Final Physician/ disease or condition MONTH Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ettending physic Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2, No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐XNo 24a. Was an certificate has b director, page 2 st autopsy Yes 2 N : After this certifica e funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 √2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Iffle of certifier 29d. Date signed (Month, Day, Year) 28/12 DO059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NACANNA JUDA POCLE RD WESTMINSTER MD 21159 COUPISHANKAR C.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AUGUST Physician/ 11:40P M 2012 GILLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL WESTMINSTER CARROLL LUTHERAN VILLAGE g. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days (Month Day, Year) 26 Hours 1 □ M 2 🛛 F 86 Director 215-22-1440 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State death with the Maryland Director 1 ☐ Yes 2 🌠 No REISTERSTOWN CARROLL 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 3691 CLYDESDALE ROAD WAY 21136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or i 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: WHITE 3 ☒ Widowed 4 ☐ Divorced Completed Al Hygiene.
J other than "natura" vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) r and Mental F 1 and 2 should be fill be the fill be the fill be the fill be filled to the filled to the fill be filled to the fill ဂ္ EPSTEIN LEVIN BELLE ABRAHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3694 ALTONDALE ROAD, REISTERSTOWN, MD 21136 CHERYL LANCASTER/DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 08/31/2012 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS Simmun of Funeral Severe Logo SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami certificate be executed Cause (Disease or iiniury pue that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year in the past 12 months?
1 ☐ Yes 2 ☐ No that the death ò Month Day Pregnant at time of death the g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown I or Attending Physician: The law requires after death.

Director: After this certificate has been sign page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🔀 No Yes 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury 1 X Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ZCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ranswella, mis D0051705

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIPA 349 (Natural Wall)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 8, per fh, g931 9-10-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year >35 TRANK LI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Loch Raven Vet.Admin.Rehab.Centler Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)1914 Maryland 1 X M 2 □ F Months Days Hours Min. Director 98 219-18-0246 04/18/2 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 28a-f Maryland Baltimore 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō Funeral 23a 21212 802 Winston Avenue USA items hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 721 other than Elementary/Seconday (0-12) Self Employed College (1-4 or 5+) Roofing Contractor 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ပ Ferdinand Hebb Macy Davis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Edith Brown/daughter 508 E.36th Street Baltimore MD.21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/11992 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Crownsville, Md. 4 Donation 5 Other (Specify) Crownsville Veterans Cem. 21. Signatura Funeral Service Ligensee 22. Name and Address of Facility Chatman-Harris Funeral Home will Laxa 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ment Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ue to (or as a consequence of) Examir that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsv perform certificate Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: If the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EBRA HEIMER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Raymond Lee Hoo	kaday 1- For State			nd / Departr	nent of	Health ar		Hygiene		201	2 279
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State of Maryland J Department of Health and Mental Hyglene  Certificate of Death  Rep 10  Certi				1 Yes 2 No							
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	23a. Part I. Enter th	ne disease, or c	complications that cau	used the death. Do i	not enter the	mode of dying,	such as cardiac	or respiratory ar	rest, shock, or	heart	Approximate Interval Between Onset and
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Gospita 4 hours functial ely fille	29a. Certifier		(Opeciny)	of my knowledge, de	eath occurred	at the time, da	te and place an	d due to the caus	o/s) and man	nor or states	
fo the P vithin 2 fo the I omplete	one) 2		iner:On the basis of	examination and/or							
Σ ۱۳۰۳	29b. Signature and	title of certifier									h, Day, Year)
	30. Name and address	ess of person w	to completed cause	of death (Item 23%)	· · · · ·	0.0.1	VI.E. OGA	1E	August 2	4, 2012	
			V		niner 90	0 W. Baltim	ore Street, E	Baltimore, MI	21223		
State Registrar		h, Day, Year) P 0 4 20		istrar's Signature	bak	,					
DHMH 17 Rev 1/2001		V	· jetate	OF	RIGINAL		·		<del></del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louis Haven 8 2012 11:39 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Rockville Montgomery Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) Director 075-03-5232 95 1 1XM 2 □ F 6-22-1917 New York Usual Residence of De item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. Count 10c. City, Town or Location the Maryland Director 1 X Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours efter death with United States 1799 E. Jefferson Street #214 20852 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked ott
any injury or other traumatic event ၉ Rita Rochelkin John Haven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1799 E. Jefferson Street, #214, Rockville, MD 20852 Roslyn Haven - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Temple Beth El Cem. Whitesboro, New York 8-28-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Edward Sagel Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hronic Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, Due to (or as a consequence of): Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Atrial Fibrillation Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 🗆 Yes 2 🗆 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🛛 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D74091 8-26-2012 е 00 Uw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zoovia Aman, MD - 6121 Montrose Road, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 4 <u>2012</u> Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #30, per DVR, 2931 9-4-12 sm
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		,	Cer	tificate	of D	eath		,	Reg. No	.20	12	2/9/0
	Physicia	n/	1. Decedent's Name (First, Middle,	,							2. Date of De Month	ath Da	av	Year	3. Time of Death
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	Examin	er	4a. Facility Name (if not institution, 9  Baltimore Wa		led.	Cent			Location on But				c. County o		ndel
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. las	st birthday)	If Under Months	1 Year Days	If Under a	24 Hrs.	8. Date of Bir (Month, Da	th			lace (State or Foreign
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	and show	tor	10a. State 10b. County		10c. City,	Town or Loc	ation		_					1	0d. Inside City Limits
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	death items		11. Marital Status	12. Was Decedent Every Armed Forces?	ver in U.S.	13. V	Vas Deced Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)			- America	an Indian, etc.
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. Box	he dea y the a iched f	Physician/	1  Yes 2 No 9 Unknown	4 Pregnant at 9 Unknown	time of di	eath 5 L	Other (sp	ecity)							
Division of Vital Records, P.O.	Attending Physician; The law requires that the death certificate or death.  sctor: After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the		Part II. Other significant condition End Stage			ilting in the u	nderlying (	cause giv	en in Part I	l.					ne cause of death?
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ivisi	l or Atter de Directo	Certificate:	3 Suicide 6 Could n 4 Homicide determin		ry - At hor . (Specify)	me, farm, stre	eet, factor	, office		2	8f. Location ( City or To	Street a	nd Numbe e)	r or Rural	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the	Medical	(Check 2 Medical Ex	Physician: To the best of e aminer: On the basis of ex Nurse Practitioner: To the	amination	and/or invest	igation, in	my opinio	n, death oc	curred at t	he time, date	and plac	e, and due	to the car	use(s) and manner stated
	To the within To the compl	2	only one) 3 \(\subseteq\) Certifying 29b. Signature and title of certifier	2			290	. License	number	_	o, and doc to	29d. D	ate signed	Month, I	Day, Year)
	1 -		30. Name and address of person w			23a) (Type, P		1)60	73			2	101		
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 Funeral Director: After this certificate has been signed by the attending physician etelly filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STAGE KIDNEY 1 Yes 2 No 3 Probably 4 Inknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of HYPERTENSION 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the Hosp within 24 hou To the Funer completely fi 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8-29-2012 ATTENDING PHYSIUM 52900

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

SEP 0

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 29,2012 JEAN ELIZABETH HESS 10:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11906 BLUESTONE ROAD BALTO. KINGSVILLE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 217-12-9624 1 M 2 X 89 JUNE 3,1923 MARYLAND Usual Residence of Deced or 28a-f show notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No WORCHESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2838 **GULL WAY** 21842 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ö þ 1 Never Married 2 Married and 2 should be filed within 72 hours after fleath and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **SECRETARY** HOSPITAL 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOHN DEMARTIN KAZIAH WEBSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN CLARKE DTR 11906 BLUESTONE ROAD KINGSVILLE, MD. 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State SUNSET MEMORIAL 9-1-2012 BERLIN, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Fyneral Service Licenses 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1. Enter the d Approximate Interval Betwe shock, or hear a each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ ò in the past 12 months? Month Day Year 9 Unknown should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2-No 1 🗌 Yes 1 🔲 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Drughters 2 PNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA Home 24 hours after death. Funeral Director: After this the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I the 29d. Date signed Month, Day, ပ္

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Registrar

DHMH 17 Rev 06-2011

State

opperson who completed cause of death (Item

12-06472 William Alfred H	arlo			or Print in E								gibl	e.	
William Amed I		1- For State	State	of Maryland			e of Dea		ia ivient	aı Hygi			201	2 2797
Physicia	_	Registrar  1. Decedent's Nam					0. 200				ate of Dea		-	3. Time of Death
Medical Exami	ner		fred Harlo	•						A	Month ugust 28			0304 hrs
		4a. Facility Name ( 304 Vale R		e street and numbe	r)		4b. City, Bel A		r Location of	f Death			County of Dea	th
Funeral		5. Social Security I		ex 7 A	ge (In yrs. la	ast hirthda		der 1 Yea	ar If Under	24Hrs 8	Date of Ri			irthplace (State or
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		Usual Residence of					Yrs.					,		odrity) state 202.2
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after d	by Fi	3 Widowed	4 Divorced	1 Yes : If Yes, Give Year or Dates:	Z A NO	1	Yes 2	2 <b>X</b> No	specify:				Specify: Whi	.te
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d with ygiene the Mer t	Completed	17. Father's Name	(First, Middle, Last						18.Mother's	Name (Firs	t, Middle,	1	_	
215 be file ntal Hr	Be (	William A.	Harloe, Sr						Marion				,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f sho injury or other traumatic eveot, the Medical Examiner must be optified at occ.	۴	19a. Informant's Na											ity or Town, Stat	e, Zip Code)
md 2 sealth ar		Mrs. Diane			20h F		Vale Ros			Maryla			Location - City o	Town State
Baltimore, Department of Hee Important: If ite				Removal from S	tate	rematory	or other place	9)				1	el Air, Me	,
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Ba perm Depa injur		frem of	Lezn	1300			Evans Fl	nera	i Chape	1 & Cre	matic	ı Ser	vices - E	el Air
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Medical Examiner		Immediate Cause (	Final disease a.	Multiple Injurie	S									Between Onset and Death
*		or condition resulting		Due to (or as a cons	sequence of	):								
	ē	Sequentially list co	nditions, b. nmediate	Due to (or as a cons	sequence of	):								
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executed an and al - transit	Ĭ	events resulting in	death) Last d.	Due to (or as a cons	sequence or	).								
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BOy e death the att	hysi	1 Yes 2 1	lo 9 Unknown	9 Unknown		0	Other (Ope	.01197		···		Ì		
that th		Part II. Other signi	ficant conditions	contributing to dea	th but not re	sulting in t	the underlying	g cause g	jiven in Part	I. 3				the cause of death?
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Division of Vital Records, talor Atteodiog Physiciae: The law requirers after death.  al Director: After this certificate has been sited in by the flueral director, page 2 should be	Certification:	1 Natural 2 Accident	5 Pending	FOUND: Day, Aug 28, 201		FOUND 0256 hrs		1 \	res 2 🗸 N	<sub>lo</sub> Subj	ect jum	ped fr	om balcony	of home
Division pital or Atteot ours after death eral Director:	E E	3 Suicide	6 Could not	28e. Place of I				, office b	uilding, etc.		ocation (S		nd Number or Ru	ral Route Number, City
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To with To com	Med	29b. Signature and		and manner stated					e number				Date signed (Mo.	
		( X a	luke 1	U)				O.C.I	M.E.				ust 28, 2012	,
3200	-	30. Name and addre	ess of person who	completed cause of	death (Item 2	23a)					_			
B. A.		Laron Locke		ant Medical Ex			Baltimore	Stree	t, Baltimo	re, MD 2	1223			
Sta	ate	31. Date filed (Mont	h, Day, Year)	2. Registra	ar's Signatur	e /.	41							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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Sharon M. Hawkinspinkney	State of Maryland / Department of Health and Mental Hygiene	2012	27071
1- For State	Certificate of Death	2012	27974

		1- For State Regiatrar	Certificate of Death Reg. No.							2 2191		
	hysician/ 1. Decedent's Name (First, Middle Last) Sharon M. Hawkins - Pinkney					2. Date of D Month		3. Time of Death				
Medical Exam	iner	SHARON M. HAWINKSPINKNEY					August	August 22, 2012 0841 hrs				
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De Southern Maryland Hospital Clinton						of Death		lc. County of Death Prince George			
Funeral		5. Social Security Number								M/DD/YYYY) 9. Bir		
Director		578-84-8662			•	Months [	Days Hours	s Min.		Foreig	gn	
	ļ		1 M 2 X F	5.	3 Yrs			04/1	9/19	WAS	HINGTON, DC	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
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Aaryland 28a-f show 1 at once.	衰	10e. Street and Number	CE GEURGE 5	l IE	IMPLE H	10f. Zip Cod	е.		10a Ci	tizen of What Cou		
th the Maryland 23a or 28a-f sho notified at once	Director		ATE TANE									
		4800 HIDDEN PIN 11. Marital Status	NE LANE  12. Was Decedent	Ever in IIS	13 1//2		748	gin? ( Specify Yes or		NITED ST	ican Indian, Black,	
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b, MD 2121 and 2 should be fi lealth and Mental i tem 27 is marked traumatic event,	ုင	19a. Informant's Name/Relation			Y			nber or Rural Route N				
MD and 2 sho alth and 2 is raumati		WAYNE J. PINKN 20a. Method of Disposition	NEY / HUSBANI					LANE, TEMP				
ore, of He of He If ite		1 X Burial 2 Cremation	on 3 Removal from St		ace of Dispos ematory or oth		cemetery,	Date	20c.	Location - City or	Town, State	
imore Pages 1 ment of F tant: If i	_	4 Donation 5 Other S		MD	VETERA			9/04/2012		IELTENHAM	, MARYLAND	
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wit Department of Health and Mental Hygen In quortant: If tiem 27 is marked other injury or other traumatic event, the M.	Π,	21. Signal re of Funeral Service	e Luonsee					JB JENKIN			•	
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Examiner		Immediate Cause (Final disease or condition resulting in death)				leroti	c Card	<u>iovacsular</u>	Dis	sease	Death	
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3876 rtificate ing phy as the		23b. Was decedent pregnant in t past 12 months?	the 1 Live birth	no or progna		al death	3 Ectopic	pregnancy	1	•	Day Year	
Box 68 death certif the attending	sici	1 Yes 2 No 9 ✔ Ur	4 Pregnant at	time of deat	h 5 Oth	ner (Specify)						
. B. he de y the	Physician	Part II. Other significant condi	9 Unknown	- h. d d	-161 1- 41			Loo- Di-	1.6-1		the cause of death?	
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V		30. Name and address of person	n who completed cause of a	leath /Item ?	32)							
			Assistant Medical Ex	•		altimore St	reet, Balti	more, MD 21223	3			
S	tate	31. Date filed (Month, Day, Year)	) 32. Fegistra					. = =				
Regis		SEP 0 4		4		Nest.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Shannon Holcomb 5:56 Рм 31 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Days (Month, Day, Year) 442-44-2906 71 **Director** 1 M 2 X F Jan. 9, 1941 0k1ahoma Usual Residence of Decedent J. Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 1X Yes 2 ☐ No D.C. Washington ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 20036 1301 20th Street, N.W. #905 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Art Historian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Department of Health and Menta Important: If item 27 is marked any lijury or other trees. Leah Featherstone pe Everett Haywood Welborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 20th Street, NW, #905, Washington, D.C. 20036 Joseph R. Morris/Companion Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Sept . 4. 2012 20c. Location - City or Town, State Montgomery crematory or other place) 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc. 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy 21. Signature of Fun Sewie Licensee M00198 7557 Wisconsin Ave., Bethesda, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final enysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, pag Holcomb, Shnnnon 1 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) August 31, 2012

Registrar DHMH 17 Rev 06-2011

State

Q

T.O.D. 1756

8600 Old Georgetown Road, Bethesda, Maryland 20814

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Philip Charles Corcoran, M.D.

31. Date filed (Month, Day, Year) SEP 0 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08month 23<sup>Day</sup> 2012 Agnes Hinton 4:20p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1515 Argonne Dr. Baltimore N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** . Social Security Number 242-54-5097 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 1 □ M 2√ F 80 01/21/1932 N. Carolina or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1515 Argonne Dr. 21218 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Engineer Private Homes it. Page 1 and 2 should be filed with trment of Health and Mental Hygien rtant: If item 27 Is marked other I njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Plummer Geneva Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Hinton(son) 1515 Argonne Dr., Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem Park 08/28/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, . Signature of Funeral Service Lices For Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, MD 21217 of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failt Immediate Caus Final aPhysician/ Due to (or as a consequence of): disease or condition 405 Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknowh g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier To the Hosp within 24 hou To the Funer completely fi 1 🂢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VILTORIA Steiner - Larson. 011 5411 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aug. 28, 2012 7:40PM Hawkins Edwina Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1824 N. Broadway If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🗌 M 2 🔲 Hours Country) 95 Director 212-22-5147 9 Georgia Apr. Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director Baltimore 1 X Yes 2 No MD 10f. Zip Code 21213 10e. Street and Number 10g. Citizen of What Country? Funeral 1824 N. Broadway 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 2 should be filed within 72 hours th and Mental Hygiene. 27 is marked other than "natura traumatic event, the Medical E. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Nursing Home 12th traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Augusta Davis Epp Goss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1824\,$  N. Broadway Balto, Md. 21213 19a. Informant's Name/Relationship (Type, Print) Deborah Gross(Daughterinlaw) I and 2 s I Health permit. Page 1 and Department of Healt Important: If item 2 any injury or other 1 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cedar Hill Cem. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Sept.7,2012 AnneArundelCo,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund vice Lic insee calvin B. Scruggs Funeral Home St. Balto, E. Preston Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final trotein Calorie Physician/ Neeks disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner years ascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 X No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b HENDING 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3572

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29c.perDVR, G931, 974/2012, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ Mamin Hartland Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore University Manyland Medical Conter N/A Birthplace (State or Foreign Country) 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, If Under 1 **Funeral** Months Hours -46-4815 Director 1 ♥M 2 □ F Pennsylvania 3, 1949 May 63 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10b. County 10c. City, Town or Location the Manyland at Director notified 1 🗆 Yes 2 🕅 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or dical Examiner must be n by Funeral Page 1 and 2 should be filed within 72 hours after death with U.S.A. 21122 443 New York Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Truck Salesman Self Employed 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Unknown Hartland, Jr. Teresa Benjamin Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health ai t: If item 27 is 7 or other trau 443 New York Avenue Pasadena, Maryland 21122 Janice F. Hartland (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of 1 X Burial 2 Cremation 3 Removal from State Important: It any injury or once. Glen Burnie, Maryland Glen Haven Mem. Pk. 08/28/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee MOO-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Ben 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Myccardial disease or condition Medical resulting in death) D to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for t in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performe 2 THO ☐ Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 - ER/Outpatient 3 - DOA မ 1 🗌 Yes 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28d. Describe how injury occurred Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: /
completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenest, Baltimore, MD 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Hunte 1401 Carol August Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** George's Hospital Center Prince George's If Under 1 Year | If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Pay Year 940 NORTH CARLINA 71 Director 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director must be notified WASHINGTON DC 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 4330 LIVINGSTON ST #C 20032 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 0 þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 'natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th DOMESTIC DOMESTIC of Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CARRIE AUSTIN FLOYD SOLOMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, CAROL P. HUNTER/DAUGHTER 4330 LIVINGSTON ST S.E. #C WASH., DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date of o 1 Burial 2 Cremation 3 Removal from State Department of Important: If it any injury or o once. 8/29/2012 BELTSVILLE, MD CHESAPEAKE CREM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service 1425 MARYLAND AVE NE WASH., DC dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease, shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final Hemosty Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav 1 Yes 2 Le 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural injury 5  $\square$  Pending Accident Investigation Acuica Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 00061555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverty, Mary (and 20785) Emergency Center Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 James Frederick Heinz, Sr. August 4:10 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 741 White Marsh Road Centreville Oueen Anne Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Director 214-24-8540 1 🕅 M 2 🗆 F 84 June 13. 1928 Usual Residence of Decedent Maryland show 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland | Queen Anne Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 741 White Marsh Road 21617 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1950-13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iter 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give 3 Divorced 4 Divorced 1952 Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Self Employed <u>Electrician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vental ျှ Health and Ment tem 27 is marked ther traumatic e Frederick Maximillain Heinz Frances Estelle Cassady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Heinz (Wife) 741 White Marsh Road Centreville, Maryland 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 08/30/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee MOO-732 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Mins 23a. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 2005 Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man r of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending Accident Investigation Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature an 29d. Date signed (Month, Day, Year) DID State SEP U 4 2012

DHMH 17 Rev 06-2011

Registrar

P.O. |

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name \*First, Middle Last. 2. Date of Death Physician/ DHNSTON 6.15 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ellicott City Health & Rehab Center Ellicott City <u>Howard</u> 8. Date of Birth (Month, Day, Year) Nov 20, 1933 **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) MD Director 215-32-5696 1 **X** M 2 □ F 78 or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Halethorpe 1 ☐ Yes 🗶 ☐ No 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be 10g. Citizen of What Country? Funeral 3014 Bero Road 21227 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) alth and Mental Hygien 127 is marked other the traumatic event, the 12 Laborer Construction Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David C. Johnston, Jr. (son) 3014 Bero Road Halethorpe, MD 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) All County Cremation 9/1/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA . Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 MO0164 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSCLEROTIC CARIDIOVASCULA DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Seque itially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STAGE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? MABETES 24a. Was an Director: After this certificate has d in by the funeral director, page 2. performed ANAEMIA 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Man r of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide (Month, Day, Year) 5 Pending work? Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 ersueen D28575 m) lau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWINGS MILL MD 21117 ASNEEM LAKHANI PO BOX 1525 MD 31. Date filed (Month, Day, Year) State 0 4 2012

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 6:00 A M 04 2012 Diana 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Arlington west Nulling Home /timore md If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 19, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2□ F July\_ 1946 MD 214-44-3606 66 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at 1 ☐ Yes 2 ☐ No Director MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6004 Oakland Mills Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any Injury or other traumatic event, the Medical Exten 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√∑No Specify. Specify: þ White 3 ¼ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Janitorial Work Janitorial 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Lewis Dorothy Trail ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Valley Drive Westminster, Mrs. Tracy Hakanson (Daughter) MD 21157 20c. Location - City or Town, State 20a. Method of Disposition Date Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 9/3/2012 Marriottsville, MD 22. Name and Address of FacilityHAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service License Hall 1007691 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) U **Physician** Emphy 44 ma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown ahemia Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Hospital: Other: 2 X No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 43386 08.30.12 ·w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tomand Macz. Real himory Echew 21217 Daniel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August JACQUELINE CAROL KELLY 23:14 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE HARFORD AIR If Under If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) 214-64-7078 58 **Director** 1 🗆 M 2 🔀 F MARYLAND 1-14-1954 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a, State **Funeral Director** Examiner must be notified MD. HARFORD 1 Yes 2 No BEL AIR è 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 1511 REDFIELD ROAD 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married "natural", or Yes 2 No Maryland 21215-0036 WHITE 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. CASE-MASON Elementary/Secondary (0-12) College (1-4 or 5+) GENERAL MANAGER FILLING, INC. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental Fishers or is marked or မ FRANK GRUBE, SR. **ALVERTA SANDERS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau PATRICK KELLY SPOUSE 1511 REDFIELD ROAD BEL AIR, MD. 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 9-2-2012 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR Signature of Funeral Service Licensee 610 W. MACPHAIL ROAD BEL AIR, MD. Rart 1 Criter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ouset and Death Physician/ disease or condition week Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Ö Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jacqueline autopsy performed 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 
Yes 1 Dipoatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Natural
Accident
Suic 5  $\square$  Pending 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C completely filled Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) SOO Upper 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) apeake HOMASON y, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Manju Kanotra 28. 2012 11:30 AM August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11303 Hawks Ridge Terrace Germantown Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours (Month, Day, Year) Months Director 217-17-3421 1 □ M 2 K F Yrs. 60 Feb. 12, 1952 India 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 X No Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11303 Hawks Ridge Terrace 20876 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🕅 No ۾ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Administration 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ည Shanti Bhandari Brij Lal Varma permit. Page 1 and 2 should by Department of Health and Mer Important: If Item 27 is mark any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11303 Hawks Ridge Terrace, Germantown, MD 20876 Surendra Kanotra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgometry crematory or other place) 1 Burial 2 Cremation 3 Removal from State September 1 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland Crematorium, Inc. re of Funeral Service Licenses Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death years Immediate Cause (Final Physician/ Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burlal-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other Company 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year signed by the a 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, Small Bowel Obstruction 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? Yes 2 X No 2 🗆 No 1 Tes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28c. Injury at 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) Woun M.D. 120 D63828 August 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Suite 435, Rockville, MD 20850 Dongmei Wang, M.D.

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day Year) SEP 0 4 2012 32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September I, Kelly 2012 Virginia С. 10:48 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 262-32-8633 Director 1 M 2 X F 90 1921 Sept. 4, Connecticut Usual Residence of Decedent th end Mental Hygiene. 27 is marked other then "neturel", or iteme 23e or 28e-f shov treumetic event, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15035 Eardley Court 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married 2 X No Page 1 end 2 should be filed within 72 hours efter ment of Health end Mental Hygiene.
ant: If item 27 is marked other then "neturel", or ury or other treumetic event, me Medical Examiliary or other treumetic event, me Medical Examiliary. Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine S. Ransom Russell B. Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David P. Kelly / Son 629 Standish RD. Teaneck, New Jersey 07666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit, Page Depertment of Important: If any injury or once. Montgomery Crematorium Inc. Sept. 3, 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Fineral Home Bethesda-Chevy Chase Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814 Jachel M01662 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Complications of pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dysphasia Sequentially list conditions, if any, leading to immediate rause. Filer Indentifing Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires thet the death certificete be executed Cerebrovascular Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No 5 Other (specify) Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice 1 ☐ Yes 2 ₹ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending ours efter deeth. Ierel Director: Af filled in by the fu 1 Yes 2 No Investigation 6 Could not be ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel C completely filled Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEP 0 4 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Bindu Joseph, MD 6001 Muncaster Mill RD. Rockville, MD 20855

32. Registrar's

D0060634

29d. Date signed (Month, Day, Year)

September 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #18 Per FH G931 9/27/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last MOSES A. KETTER 2. Date of Death JR. Physician/ Month 8 12°  $1^{3}$ 11:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>MONTGOMERY GENERAL HOSPITAI</u> MONTGOMERY Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours (Month, Day, Year) 346-52-0738 60 **Director** 1 XM 2 □ F 7/5/1952 LIBERIA Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 ¥ Yes 2 □ No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 4213 HEATHFIELD RD 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married ō 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes X No Specify: "natural", 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) **5 +** Elementary/Secondary (0-12) FINANCIER PRIVATE To Be 18. Mother's Name (First, Mydic Meider Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o MOSES A. KETTER SR. CATHERINE HARMON 19a. Informant's Name/Relationship (Type, Print)
MONICA WRIGHT/SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4213 HEATHFIELD RD. ROCKVILLE, MD 20853 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗌 Burial 2X Cremation 3 🗆 Removal from State 9/8/2012 BELTSVILLE, MD 4 Donation 5 Other (Specify) CREM 22. Name and Address of Facility CAPITOL MORTUARY 21. Sign were of Funeral Service Licensee MARYLAND AVE NE WASH., DC 23a. Part 1. Enter the disease, o shock, or heart failure. List Approximate Interval Between Malignant Onset and Death Immediate Cause (Final Melanoma Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔃 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within 2 To the I Conard D 28791 30. Name and address of person who completed cause of death (Items 23a) (Type, Print) 2011. Print Philip Drive, Olney, MD 20832

DHMH 17 Rev 06-2011

State

Registrar

(Month, Day, Year)

SEP 0 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 18 Day 2012 Year Physician/ Lecky 7:57 A M Inez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 6 Sex **Funeral** Min (Month, Day, Year) 111-32-8416 Director 1 M 2 X F 82 Feb. 5, 1930 Cuba Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Prince George's Laure1 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? ò ir than "natural", or items 23a o the Medical Examiner must be Funeral USA 20707 304 11th Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 2 X No ò 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Cuban If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Garment 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F ပ္ Roslyn Mitchell William Lecky traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 si ment of Health a tant: If item 27 is Diana Mills Lynch 335 E. 32nd St., Brooklyn, NY 11226 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. ☐ Bynal 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Greenwood Cremation 8/31/2012 Brooklyn, NY Other (Specify) 4 Donation \$ 22. Name and Address of Facility Metropolitan Funeral Service 21. Sign ture of Fur ral Service Lice see un 22310 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provincion/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery | Live Birth 2 | Fetal death 3 | Ectopic pregnancy |
| Pregnant at time of death 5 | Other (specify) | in the past 12 months?
1 Yes 2 No ed by the at detached for 1 Yes 2 Unknown Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown DICUBITI ULCER 24b. Were autopsy findings available prior to completion of cause of death? SACRAL 24a. Was an After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 2 28a. Date of injury (Month, Day, Year) ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

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🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) · Chandras Eklin 8-2012 MD 52855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7207 Hanover Parkway, #B, Greenbelt, MD Chandrasekhar Korapati

32. Registra s Sign

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	Sta	ate of M	aryland		artment of I <i>tificate of I</i>			lental Hy		201	2	27988
	Physicia	n/	1. Decedent's Name (First,	Viiddle, Last)					Journ		2. Date of De	Reg. No			. Time of Death
يسائم	Medi	cal	MARY ANN  4a. Facility Name (if not insti		CKETT						Augus				9:10 AM
اريد	Examir	ier	Laurel R	egional	Hosp	pital		4b. City, Town, o	ure			40	Prince	$e^{\text{ath}}G$	eorge's
	Funeral Director		5. Social Security Number 067-34-3649	6. Sex		e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Und	der 24 Hrs. Min.	8. Date of Bir (Month, Da	th	g. E		(State or Foreign
			Usual Residence of Deced		LXI F	69	Yrs.				JAN. 4,	, 19	43 WAS	SHING	GTON, DC
	uyland a-f sho ied at	Director	MARYLAND PR	ounty LNCE GEOR	CFIS	,	Town or Loc UREL	ation							Inside City Limits
	the Ma or 28a e notif	<u>P</u>	10e. Street and Number		GL 5	LA	UKEL	10f. Zip Code			- Т	10a. Ci	itizen of What (		1 X Yes 2 □ No
	th with ns 23a must b	Funeral	10095 WASHIN					20723				UN	NITED S		S
920	e filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div	Married Arr	as Decedent E med Forces? Yes 2 X Yes, Give ar or Dates.			/as Decedent of H Yes, specify Cuba			cify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify:		·
21215-0036	72 hour "natu edical	Completed	15. De (Specify only	cedent's Education highest grade com	n epleted)		(Give k	ent's Usual Occup	during m	ost of workir	ng	16b. K	(ind of Busines	s/Industr	у
212	ed within 7 Hygiene. other than ent, the M		Elementary/Secondary (0 12TH	-12) Col	llege (1-4 or 5	+)		NOT use retired) INISTRAT					GOVERN	MENT	1
pu	ould be filed wind Mental Hygie marked other matic event, til	To Be	17. Father's Name (First, Mid						18. Mo		(First, Middle,		Surname)		
Maryland	2 should be file th and Mental 27 is marked of traumatic eve		JAMES  19a. Informant's Name/Rela	PARKER	nt)		10b Mailine	g Address (Street		KEY	Davida Mussia		EE		LMORE
Ž,	1 and 2 shoot Health an item 27 is other trau		DONALD LUCKE		_			,				. ,			ND 20723
Baltimore,	ige 1 and nt of H.  t: If itel  r or oth		20a. Method of Disposition 1 Burial 2 X Crem	ation 3 🗆 Remov	al from State	cer	netery, crem	ition (Name of atory or other place			ate		ocation - City o	,	
altin	permit. Page 1: Department of I Important: If it in viury or of	Н	4 ☐ Donation 5 ☐ Ot 21. Signature of Functal or			TKIVE		CREMATO Name and Addres			/2012 JENKINS		VERDALE NERAL H	-	
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	Physician/ Medical		23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only one cause	s that caused e on each line. Letha Due to (or as a	al A	Arrhy	the mode of dyin	g, such a	as cardiac or	respiratory an	rest,		Inte	proximate rval Between set and Death
مر	Examiner	).r	Sequentially list conditions,	b. —	,										
	ted Insit	Examiner	if any, leading to immediate cause. Enter onderlying Cause (Disease or injury	<	Due to (or as a	conseque	nce of):								
	execu ian and irial-tra	I Exa	that initiated events resulting in death) Last	c	Due to (or as a	conseque	nce of):								
200	cate be executed physician and s the burial-transi	edical		d										1	
		ΣΙ	IF FEMALE: 23b. Was decedent pregnam in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 4	es, outcome o Live Birth 2 Pregnant at Unknown	2 🗌 Fetal o	death 3 🗌	Ectopic pregnanc Other (specify)	:y				23d. Date of d Month	elivery Day	Year
ds, P.O.	requires that to been signed be should be deta	þ	Part II. Other significant co	nditions contributir	ng to death bu	rt not result	ing in the un	derlying cause giv	ren in Par	rt I.			se contribute t		use of death?
Division of Vital Records,	ician: The law re certificate has be rector, page 2 sh	Completed	25. Was case referred to med	lical							24a. Was a autop perfo	sy .	prior to	complet	ndings available ion of cause of No
Vita	ysiciai is certi directo	To Be	examiner? 1  Yes 2 No	Hospital	: 1  Inpatie	nt 2 EF	₹/Outpatient	Othe	or.	eath (Check o		lence 6	Other (Spe	cifu)	
on of	To the Hospital or Attending Physiciam: within 24 hours after death to the Funeral Director. After this certifica completely filled in by the funeral director,			ending vestigation	. Date of injury (Month, Day,		Bb. Time of injury	28c. Injury work M 1 $\square$	at	28	3d. Describe h			J.,,,	
Divisi	ital or Attend urs after death ral Director: /	al Certi	4 ☐ Homicide de	sterrillied	building, etc.	(Specify)		t, factory, office			City or Tow	n, State)			e Number,
;	To the Hospita within 24 hours To the Funeral completely filled	Medical	only one) 3 Certi	fying Physician: To cal Examiner: On t fying Nurse Practi	ne pasis of exa	amination a	na/ar investic	lation. In my opinio	n death	occurred at ti	he time date a	nd place	and due to the	COLLEGE!	and manner stated.
	70 W.i		29b. Signature and title of ce	tifier	7			29c. License		3086		29d. Dat	e signed (Moni	th, Day, Y	ear)
			30. Name and address of per		d cause of de	ath (Item 23	Ba) (Type, Pri			Van I	Dusen	त्व	Lau	rel,	MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Day 29 Physician/ Year 2012 1532 ewis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University 07/ Momland Medical Baltimore MD 21201 . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sep 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 226-48-8141 **Director** 1 □ M 2 🔀 F 77 Virginia June 18,1935 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington MD Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 369 Thames Street 21741 United States 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian ģ 1 Never Married 2 Married 2X No Yes, Give 1 Yes 2 No Specify. Completed 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Medical Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest Lyle McCraw Bertha Lawhome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart Lewis- Son 369 Thames Street Hagerstown, MD 21741 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September Eversify Crematory or other place)

Eversify Funeral

Chapel Bel Air 1 Durial 2 Durial 2 Removal from State Forest Hill, 4 Donation 5 Other (Specify) 2, 2012 Name and Address of Facility
vans funeral Chapel & Cremation Services Evans 8800 Harford Road Parkville, nd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one caus, on each line. Immediate Cause (Final Onset and Death Physician/ Cute Kessiratory Medical resulting in death) Examiner Un Known Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as con quence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day signed by the a 2 No Unknown 9 🗷 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2 🔀 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔼 No Other: ည 1 

Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Director: A 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Extrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle 29d. Date signed (Month, Day, Year) MO 2012 ddress of person who completed cause of death (Ite 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19b, 20b, per fh, g931 9-11-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Anna Long August 31 2012 2:25 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester Carrol1 Social Security Number 8. Date of Birth Nov • 5 , 1926 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 🗶 🗓 F Hours New York Director 214-26-2161 85 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes XXNo MD Baltimore Reisterstown 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 119 Caraway Rd. Apt. 1A U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes XX No Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates White "natural", XXWidowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker 12 Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) unk • 17. Father's Name (First, Middle, Last) 2 Albert Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 119 Caraway Rd. Apt. 1A Reisterstown, MD 2111 John S. Long / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/5/2012 Grace Church Cemetery XX Burial 2 Cremation 3 Removal from State 9/12/2012 4 Donation 5 Other (Specify) Reisterstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) eav3 Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 ho 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: Hospital or Attending s after dea. Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C

completed filled Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 037573 31,2012 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Salisbury Zbell VO Box 2613 31. Date filed (Month, Day, Year) State Registrar

Baltimore.

Box 68760<

P.0.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death LLIAM Physician/ Manth 45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4 N. Meadow Drive Glen Burnie Anne Arundel Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) 196-34-8814 Director 1 🖾 M 2 🗆 F 69 May 23, 1943 Pennsylvania ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 4 N. Meadow Drive 21060 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No Korean
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates. Conflict Specify: White Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouseman Coffee Supply Service 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Phillip. Lambert permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Laverne Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret K. Lambert /wife 4 N. Meadow Drive Glen Burnie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery | 09/06/2012 | 4 Donation 5 Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Part 1. Enter the disease, or complications that states shock, or heart failure. List only one cause on each line, lediate Cause (Final ase or condition Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? After this certificate 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital ON No 1 🗌 Yes <u>မ</u> 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1945 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMONTH Physician/ 3:50 evine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 40 ursing timove a If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Min. Months Days Hours 93 214-46-1791 1070971918 Mary Tand Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 121 Ridge Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò ☐ Yes 2 🛛 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ္ George Beyer Ada Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Petrusik / daughter 121 Ridge Avenue Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Memorial 09/04/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nieumoni Ph\_sician disease or condition resulting in death) Medical consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sord en Cause (Disease or linjury that initiated events ZWVe attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔏 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No. Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year 2012

State Registrar nu

2122

and

Name and address of person who completed eause of death (Item 23a) (Type, Print)

32, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Paul G. Misinger Physician/ 17:12 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year)
Jan 27, 1934 215-30-2340 **Director** 1**X** M 2 □ F 78 MD Usual Residence of Deceden 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits notified 28a-f MD N/A Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3838 Roland Avenue Apt. 811 21211 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married ō þ Black, White, etc. Yes 2XX No Yes, Give 1 ☐ Yes XX No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Stationary Engineer Johns Hopkins University Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Glen C. Misinger Catherine V. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Charlotte Misinger (Wife) 3838 Roland Avenue Apt. 811 Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Woodlawn Cemetery 9/5/12 Balto, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disea Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COP Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Physician/Medical as 1 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year the 9 Unknown ó det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a Was an autopsy performed Yes 2 has Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 200 No ပ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA n 24 hours after death.

e Funeral Director, After the letely filled in by the funeral 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred 10 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Accider☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. AT2438946-I3

State

Date filed (Month, Day, Year)

SEP 0 4 2012

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Registrar

DHMH 17 Rev 06-201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

th (Item 23a) (Type, Print) Hootan Forghan;
20 | East university parkway

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ancuso 20/2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **MANCHESTER** CARROLL LONGVIEW NURSING HOME 7. Age (In yrs, last birthday)

90 yrs If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

NEW JERSEY 8. Date of Birth (Month, Day, Year) 9-26-1921 5. Social Security Number 6. Sex Days Months Hours Min 1 □ M 2 X F 154-05-1647 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 1 □Yes 2 XNo Director MD. CARROLL MANCHESTER 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3332 HANOVER PIKE 21102 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. WHITE à Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HT8 COOK COUNTRY CLUB 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FELIX FAZZIO ROSALIA LOMBARDI ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANTHONY MANCUSO SON 3604 PICNIC GROVE ROAD MANCHESTER, MD. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-30-2012 GLEN BURNIE, MD. ATLANTIC CREMATORY 4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tears Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter U denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2☑No 3☐ Probably 4☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 272 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner that the death certificate be executed and burial-tra Box 68760. aftending physician for use as the buria o the ₫. by Division of Vital Records, page 2 s has certificate director, Hospital or Attending death. after death

Director: 24 hours a completely filled

**Funeral** 

Director

28a-f show

items 23a

'natural", or

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, If a Mental once.

**Physician** 

/Medical

death 1

hours after

filed within 72

Baltimore, Maryland 21215-0036

id other than "natural", or items 23a or 28a-f shov event, it a Madical Examinational be notified at

within 2

Medical

Registrar

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a, Certifier



Po

and manner stated

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

037573

Salisbr

29d. Date signed (Month, Day, Year)

21805

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SYRED of Mary and Poseparine of Health and Wental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 1. Yolanda F. Miara 2012 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 235-20-9650 Director 1 🗆 M 2 🗓 F 89 West Virginia April 6. 28a-f show 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Maryland Prince Georges Laurel 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a ( Funeral death with U.S.A 8120 Fenwick Ct. 20707 or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2XX No δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates White "natural", 3 XXWidowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Navy Yard - Defense Dept. Clerk - Civilian Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anthony James Flora Angioletta Olmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Miara (Son) 8120 Ferwick Ct. Laurel. MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) September 6, 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery Clinton, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Liger 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, tany, leading to imprediate cause. Enter Underlying Cause (Disease or injury Due to (or se s consequence of Examir attending physician and after transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 X No Month Day Year the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) D 69430 September 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nega Ali Goji 7300 Van Dusen Rd. Laurel, MD 20707 31. Date filed (Month, Day, Year) SEP 0 4 201 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fulton Wayne **Marshall** 12:15a м August 29 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Stella Maris Hospice Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 23, **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 215-92-5724 Hours **Director** 1**X** M 2 □ F 49 1963 Virginia 28a-f show 10a. State 10b. Count 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be 2757 Moorgate Road Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, a.m. 1 Never Married 2 X Married Black, White, etc. by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify Year or Dates. \$3 - \$9 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 12 years Information System Tech Analysist Communications years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond W. Jones Eugene Franklin Marshall ပ Madeline Carroly Shiftlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Marshall Wife Page 1 and 2 2757 Moorgate Road, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of September 1, 2012 20c. Location - City or Town, State permit. Page 1 and Department of F AUGUST crematory or other place) 1 Surial 2 Cremation 3 Removal from State Holly Hill Memorial Middle River, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Lice see Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a/Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a non-sequence of) cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 FULTON MARSHALL for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No 9 Unknown signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate has I performe ☐ Yes 2 🗶 No completely filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date sigged (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM. MD 21093 32. Registrar State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Miles 13:57 Lee August 3/ 2017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 3,1938 **Funeral** Months Days Hours Min. 213-36-0524 Director MAryland Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Dundalk 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 0 items 23a 3210 Mc Shane Way 21222 USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-: any Injury or other traumatic even. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel 12 years 2 vears Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Gordon Sparks Leycester M. Miles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Miles wife 3210 Mc Shane Way, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Septeliber 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6, 2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a contiquence of): 7045 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed y physician and as the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hypertension: Hyperlipidemin 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Ves 2 certificate has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 T Homicide City or Town, State) The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MO D0069477 August

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pham

32. Registrar's Signature

Gemanh

31. Date filed (Month, Day, Year)

SEP 0 4 2012

2012

4940 Eastern Avenue, Baltimore, MD, 21224

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chard Henry N	viaia	Chart of the June 1	ent of Health and Mental H hate of Death	ygiene	2012 2799
Dharini	1	Registrar  1. Decedent's Name (First, Middle, Last)	te oi Dealli	Reg. N 2. Date of Death	3. Time of Death
Physici Exami		Richard Henry Malat		Month Da August 27, 20	v Year
T.		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		315 Hickory Point Road	Pasadena		Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth			IM/DD/YYYY) 9. Birthplace (State or
Director		218-36-7481 1XM 2 F 72	Yrs. Months Days Hours Min	08/27/19	40 Foreign Country) Maryland
		Usual Residence of Decedent			
w any		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
Maryland 28a-f show d at once.	Ď	Maryland Anne Arundel Pasadena			1 Yes 2 X No
Mary r 28a ed at	irec	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
5-0036 Substitute of the Maryland of the Maryland of the than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	<b>Funeral Director</b>	315 Hickory Point Road  11. Marital Status   12. Was Decedent Ever in U.S.	21122  13. Was Decedent of Hispanic Origin? (Sp		U.S.A.  14. Race - American Indian, Black,
ath w	ner	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		White, etc.
fler de		$1 \times 10^{1} \text{ yes}$ $1 \times 10^$	1 Yes 2 No specify:		Specify: White
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5-0036 led within 72 hou Hygiene. other than "nat	Completed	12 4	Insurance Broker		nsurance Agency
15- filed of oth		17. Father's Name (First, Middle, Last) Anton Malat	Josephir	(First, Middle, Maid	en Surname) Gac
21215-003 build be filed within I Mental Hygiene. marked other the	To Be		Mailing Address (Street and Number or F		-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Martal Hygiers. Important: If iten 27 is marked other than injury or other traumatic event, the Medica	_				ooklyn New York 1121
l and l'Healt			Disposition (Name of cemetery, ry or other place)	Date 20	c. Location - City or Town, State
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service Licensee M00-732	22. Name and Address of Facility		
		Shith	McCully-Polyniak F 3204 Mountain Road	Tuneral Ho Pasadena	Maryland 21122
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		Sequentially list conditions, b			
	ner	if any, leading to immediate cause. Enter Underlying Cause			
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n of Vital Records ing Physician: The law requi After this certificate has been funeral director, page 2 should	P_	1 Yes 2 No	patient 3 DOA Nursin  me of Injury 28c. Injury at Work?	g Home 5 Resi	dence 6 Other: Scene
Division of Vital Records, tal or Attending Physician: The law requires after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	ion:	1 Natural 5 Pending FOUND FOUND FOUND	ID: 1 Yes 2 ✓ No	Probable fall	mary occurred
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	Suicide 6 Could not be determined (Specify) Single Family Ho	me	or Town, State) 315 Hickory Point	Road, Pasadena, MD
Hosp 24 hor Fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death			
Fo the within Fo the	Medical	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.		t the time, date and p	place, and due to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
		Tate Un- Mollet -	O.C.M.E.	AL	Jgust 28, 2012
10x,		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Patricia Aronica-Pollak MD. Assistant Medical Examin</li> </ol>	ner 900 W. Baltimore Street, B	altimore MD 21	1223
	ate		·		
Regist		31. Date filed (Month, Day, Year) SEP 0 4 2012 32. Registrar's Signature	Ver		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death c. County of Death N/A 1824 Jackson Street Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 217-38-3498 1 🗆 M 2 🗓 F Yrs. March 6, 1941 Maryland 28a-f show th and Mantai Hygiana. 27 is marked other than "natural", or Items 23a or 28a-f sho traumatic evant, the Medical Examiner must be notified at Paga 1 and 2 should ba filad within 72 hours aftar daath with tha Maryland ment of Haaith and Mantai Hyglana. Thent of Haaith and Mantai Hyglana. Ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho 10a, State 10b, County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 <u>1824 Jackson Street</u> U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 24 No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kane Catherine Richard Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1824 Jackson Street Baltimore, Maryland 21230 Catherine M. Muir (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Important: It any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 08/30/2012 Glen Burnie, Maryland Signature of Funeral Service Licensee MOO-732 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 East Patapsco Avenue Baltimore, Maryland 21225 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest strick, or heart failure. List only one cause open thine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated according Due to (or as a consequence of) Exami To the Hospital or Attending Physician: Tha law raquiras that the death cartificata be axecuted within 24 hours after death.
To the Funeral Director: After this cartificate has been signed by the attending physician and complataly filled in by the Inunated for use as the build-transit complataly filled in by the Inunated infector, page 2 should be deteched for use as the build-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 1 Tes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 20 No ဥ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Certificate: 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a d title of certi ath (Item 23a) (Type, Print) 1. Date filed (Month, Day, State

Registrar
DHMH 17 Rev 06-2011

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

manes willer, o		1- For State Registrar Certificate of Death Reg. No. 2012 2800
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  4.040 here
MEGICAI EXAMI	nei	CHARLES NEWTON MILLER, JR. August 28, 2012  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		Baltimore Washington Medical Center Glen Burnie Anne Arundel
Funeral Director		5. Social Security Number 6. Sex 13-66-8506 1X M 2 F 58 Yrs. 58 Yrs. 17. Age (In yrs. last birthday) 58 Yrs. 18. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign MARYLAND Country) 9. Birthplace (State or Foreign MARYLAND Country)
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
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r death with the Maryland or items 23a or 28a-f sho must be notifited at 90cc.	I Director	10e. Street and Number 8350 COLONY CIRCLE 10f. Zip Code 21601-7197 10g. Citizen of What Country? U.S.A.
	y Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 5 No 5 No 5 No 5 No 5 No 5 No 5 No
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136 hin 72 l e. than "1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 TH  SURVEYOR  TRIANGLE SURVEY
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21215-0036 ould be filed within 72 hours afte 1 Mental Hygiene. 1 marked other than "natural", ic event, the Medical Examiner.	Be	CHARLES NEWTON MILLER, SR. AGNES COLOFEN
프 말씀 볼 때	Ը	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  COREEN CIESLAK - SISTER  7346 GREENBANK ROAD BALTIMORE, MD.21220  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, AUCHST 20c. Location - City or Town, State
Baltimore, permit. Pages I as Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 31,2012 BALTIMORE, MARYLAN
altim nit. Pa sartmer sortson		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  MO0933  BAYVIEW CREMATORY  J1, 2012  BAHTITIORE, THREEDING.  MO0933  22. Name and Address of Facility ACZOROWSKI FUNERAL HOME, PA
B Pa B	1 19	1201 DUNDALK AVENUE BALTIMORE, MD 21222
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Driset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):
		Sequentially list conditions, b.
	miner	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause (Disease or injury that initiated  C.
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Vital I hysiciae: this certifi al director,	To Be	examiner? 1 Yes 2 No   Hospital: 1 Inpatient 2   ER/Outpatient 3 DOA   Other4 Nursing Home 5 Residence 6 Other:
Division of Vital Records, P.O. Box 68760, To the Hospital or Attendiog Physiciao: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transi	ation:	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No
Divisior To the Hospital or Atteod within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
),, 1	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 29, 2012
10 Nic		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
St Regist		31. Date filed (Month, Day, Year) 82. Registrar's Signature SEP 0 4 2012
DHMH 17 Rev 1/2		ORIGINAL
OCME 2006		OCME